DOCUMENT RESUME

ED 264 804 HE 018 986

AUTHOR McMurray, Anne
TITLE Task Performance Requirements of the Community Health Nurse: Implications for Curriculum Development.
PUB DATE Oct 84
NOTE 302p.; Master's Thesis, University of Western Australia.
PUB TYPE Dissertations/Theses - Master Theses (042) -- Reports - Research/Technical (143) -- Tests/Evaluation Instruments (160)

EDRS PRICE MF01/PC13 Plus Postage.
DESCRIPTORS *Community Health Services; Competence; *Education Work Relationship; Foreign Countries; Higher Education; *Job Skills; *Nurses; *Nursing Education; Occupational Surveys; Professional Continuing Education; Public Health; Questionnaires; *Role Perception
IDENTIFIERS *Australia (Western Australia)

ABSTRACT

Tasks required of nurses in community settings were investigated as an initial step in identifying the competencies that comprise the role of community health nurse (CHN). An instrument to assess task performance was devised as a survey mailed to 376 field, outpost, child health, and school health nurses employed by the Western Australia Health Department. Responses from 96 participants on 3 survey days categorized tasks according to number and type of tasks performed, source of initiation (self, supervisor, client, other) and perceived degree and source of preparation for task performance. The questionnaire also gathered information on the nurses' perceptions of educational needs and role requirements. Analysis of responses according to functional, educational, and experiential categories suggest that task performance is context specific, rather than dependent on education or experience level. It was recommended that several content areas be added to existing community health nursing curricula. Improvement in educational service delivery to nurses practicing in nonmetropolitan areas was also recommended. A literature review was conducted covering historical developments pertinent to nursing education in Australia and abroad, education needs for the current role of the CHN, and educational preparation of the CHN. The questionnaire is included. (Author/SW)

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TASK PERFORMANCE REQUIREMENTS OF THE COMMUNITY HEALTH NURSE: IMPLICATIONS FOR CURRICULUM DEVELOPMENT

BY

ANNE MCMURRAY, R.N., B.A.

A thesis submitted to fulfill the requirements for the degree of Master of Education at the University of Western Australia.

-October, 1984-

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ABSTRACT

The study investigates tasks required of nurses in community settings as an initial step in indentifying the competencies which comprise the role of community health nurse. An instrument to assess task performance was devised as a survey mailed to 376 field, outpost, child health and school health nurses employed by the Health Department of Western Australia. Responses from 96 participants on three survey days categorized tasks according to number and type of tasks performed, source of initiation (self, supervisor, client, other) and perceived degree and source of preparation for task performance. The questionnaire also gathered information on the nurses perceptions of educational needs and role requirements. Analysis of responses according to functional, educational, and experiential categories suggest that task performance is context specific, rather than dependent on education or experience level. Recommendations included the addition of several content areas to existing community health nursing curricula , and improvement in educational service delivery to nurses practising in non-metropolitan areas.

ACKNOWLEDGMENTS

I would like to acknowledge the invaluable assistance provided by Professor Michael Scriven, Dr. David Andrich, Mr. Alan Lyne, and the staff in the Education Department office, University of Western Australia.

My appreciation is also extended to Dr. John McArthur, whose information and encouragement permitted the study to be situated within the current Australian nursing research perspective, and to Noelene and Brian, whose helpfulness enabled me to proceed without interruption.

Most importantly, I would like to thank the nurses of Western Australia who advised, suggested, and participated in the study, particularly Joan Bedford, who, once more, delayed her own pursuits to advance the spirit of collaboration.

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CHAPTER ONE

THE PROBLEM

0.1 INTRODUCTION

The following study presents a description of performance requirements of the community health nurse in Western Australia, with a view toward determining the educational needs of current and future community health nurses. The basis for this investigation is the expectation that those nurses currently engaged in community health nursing practice will provide the most insightful information on their role requirements and correspondent educational needs. The focus of the study has therefore been on the community health nurses practising at present within the Health Department of Western Australia, and it is through the kind permission of the Commissioner of Public Health and the cooperation of the Community Nurses Division of the Health Department that the study has been undertaken.

The study surveys this group of nurses in the context of background information relative to educational preparation for community health nursing. Review and analysis of this information form the basis of recommendations regarding curriculum planning for

community health nursing.

0.2 BACKGROUND

Since the first Australian school of nursing was established at Sydney Hospital in 1868, Australian nurse educators have attempted to keep abreast of educational needs of their students, by evaluating the practice performance of these students. In turn, this has provided feedback on the appropriateness of nursing curricula.

Measurement of quality of practice performance against a standard is a key element in the competency-based education movement (CBE) which originated in the late 1960's as a method of teacher education. It stemmed from a "pragmatic concern for doing, not just knowing how to do, what is most effective in achieving behaviourally stated objectives." (Houston & Warner, 1977, p. 14). The movement was well received by nurse educators anxious to systematically evaluate outcomes which are the consequences of nursing care behaviours, as distinct from those outcomes of the combined inputs of the situation, client, and health care system. A

competency based framework has therefore been anticipated as a vehicle from which to approach the objective, of "congruence between the planned teaching/learning strategies and the measurement of learning outcomes". (Scott, 1982, p. 123). [1]

The 'nursing process', a management system of "individualized, and comprehensive organisation of care through application of the problem solving process" (Royal Australian Nurses Federation, 1980, p.p. 18-19), has become the profession's semantic for CBE. Under the guidance of such authors as Marriner (1979), and Lamonica (1979), nurses are taught to provide health care according to the systematically organised steps of assessment, planning, implementation and evaluation.

As epidemiological outcomes are one measure of combined client care inputs, so discrete units of change in the client's health status, attributable to nursing interventions, reflect 'nursing process' outcomes. Outcome measures enable evaluation and revision of appropriate nursing actions. These outcomes to the client or recipient of nursing care therefore contribute to the knowledge base from which competencies comprising the role of the effective nurse

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1. Throughout the study, the term 'client' will be used to designate the health care consumer.

is derived. However, when nursing is seen as wellness oriented, such as in tasks of health maintenance or prevention, or when it is conducted in a non medical environment, outcomes of the nursing process are difficult to assess.

The practice setting of the community health nurse (CHN) presents an example of wellness oriented nursing. In the community, nursing is conducted as an interactive process with the client in the context of his or her environment. (see Fig. 1).

Figure 1: The Nursing Process

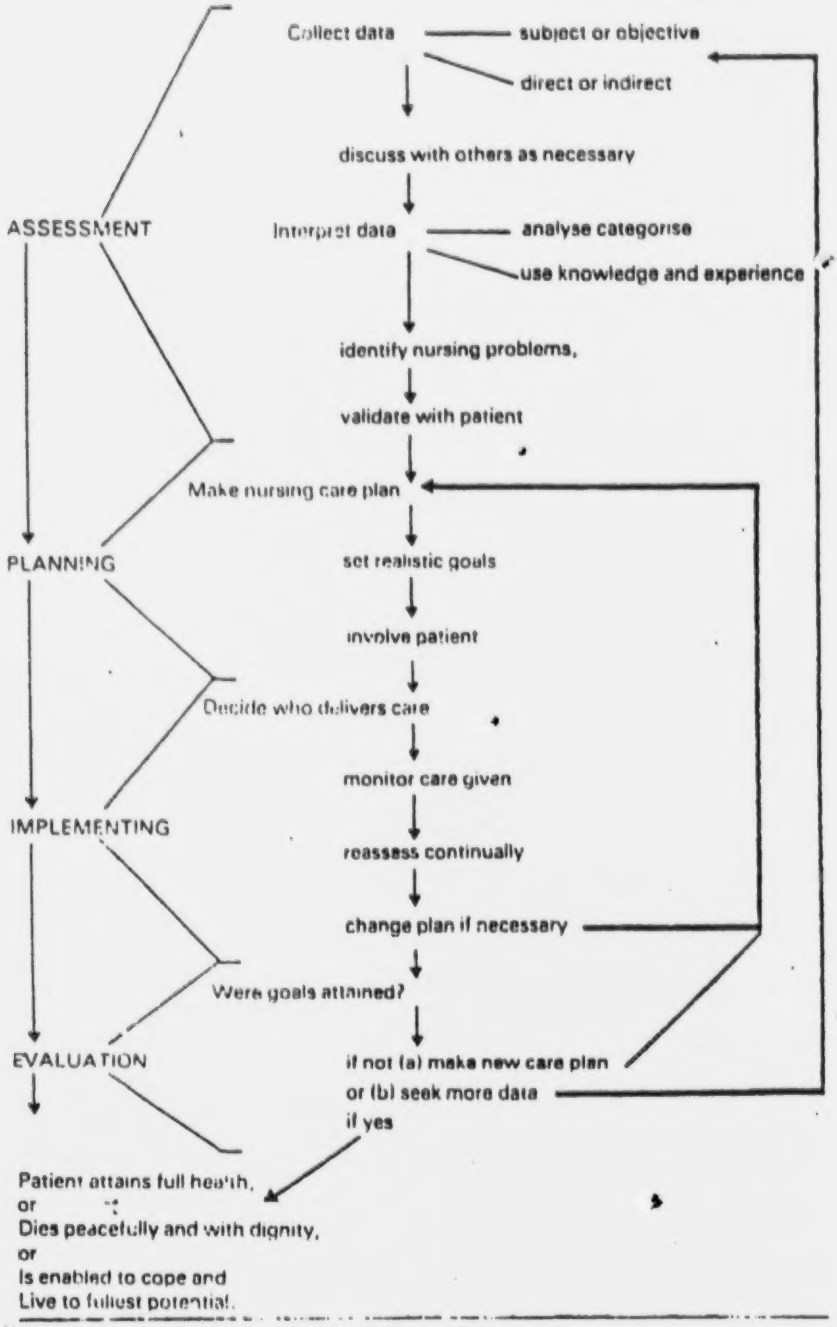

Fig 1. *The nursing process*

Robertson, 1981, p. 1299. Reproduced by kind permission of Nursing Times.

The usual function of the CHN is as primary care nurse, defined by the Royal Australian Nurses Federation (R.A.N.F.) (1980, p. 19) as "the person's first contact with any health professional who decides what must be done to solve his or her problem." As a theoretical basis for effective nursing care delivery, primary care must, therefore, be viewed as Greiner (1983, p. 205) suggests: a "problem-solving decision-making process, not a role or a series of competencies attributed to a title."

The process of problem solving, according to Argyris (1982, p. 38), often presents a new problem in each solution. Such is the case in primary care, where decisions of varying magnitude compound and overlap, demanding nebulous competencies. Each step taken must be evaluated in the context of beneficial client outcome, strategies for time and resources management, and potential outcomes to the community as a whole. Some doubt is therefore cast on the utility of traditional, or client outcome measures of nursing competency in the primary care setting. Hence, although Greiner contends that the basic nursing process is "unrecognized, undervalued, and needs to be articulated," (p. 205) alternate methods of elaboration must be sought.

A note of caution against competency-based

measurement of nursing practice is advanced by Benner, (1982, p. 309):

> "To overestimate the power of competency-based testing will cause an undesirable reductionism in nursing. To conform to our testing capacity is to have ordered our priorities perversely."

This author succinctly describes the dilemma of those faced with the responsibility of ensuring quality of educational programming. The problem, which Benner has recapitulated, lies in deriving curricula from over-quantified nursing performance outcomes. A hazard in systematising the process is that, in becoming preoccupied with nursing performance appraisal, the system of interactive problem-solving may be compromised, leaving client care goals unattended to. Prior to definition of nursing competencies, the important question for educational planners would thus seem to involve identification of client needs, the nurses' preparation to meet those needs and the effects of contextual factors on both. Benner suggests an approach which would interpret meaning from context. This could be best achieved by an appraisal of task performance requirements within the practice context by those performing the tasks; and relating perceived sources of educational preparation for such performance requirements. This may well be the only way to evaluate the reality oriented outcomes of education programmes directed at the nurse in the community, and

to provide definitive statements on the competencies required of the CHN. A system of education can then be derived from interpretation of performance requirements in context. Such is the object of the present study.

0.3 HISTORICAL PERSPECTIVE

The 1976 document 'Goals in Nursing Education' represented the concerted effort of a profession mobilised by the conviction that "traditional methods of nurse education were no longer adequate in preparing nurses to work within a rapidly expanding work environment." (p. 10).

The Goals' statement urged comprehensive programmes to prepare two types of nurses: the professional nurse, and the auxiliary nurse; distinguished by two different levels of decision-making required of each in the practice setting. This delineation is derived from the concept of primary care and designates the registered nurse (R.N.) as primary care nurse. An R.N. is a nurse who has completed the registration function for one or more of the ten nursing divisions presented under the Nurses Act. An auxiliary nurse is one who is qualified to perform general nursing care under professional nursing supervision (A Survey of Nursing Manpower in Western Australia, 1981, p. 3).

The Goals statement further directed that the present apprenticeship style of hospital-based nurse training be replaced with college-based programmes for both levels of nurse provided in multi-discipline institutions: the professional at not less than tertiary diploma (UG2) level, and the auxiliary at sub-tertiary level.[2] A hospital-based school of nursing is a school affiliated with a hospital or group of hospitals, in which the R.N. student is enrolled for a three year programme of study and simultaneously employed by that hospital or hospitals to provide nursing services alternately with attendance at lectures and instruction. A college-based programme is one in which courses are provided at a tertiary institution, and the nursing student is alternately assigned to a health care institution for clinical instruction and supervision. The student is not employed by such institutions and is supernumerary to existing staff. Tertiary institutions include Universities, Colleges of Advanced Education (C.A.E.),

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2. The levels of nationally accredited awards in advanced education as defined by the Australian Council on Awards in Advanced Education are as follows: UG 1 - Bachelor Degree; UG 2 - Diploma; UG 3 - Associate Diploma; PG 1 - Postgraduate Diploma; PG 2 - Masters Degree. (Source: Tertiary Education Commission. Report for 1982-84 Triennium. Vol. 1, Part 1, Recommendations on Guidelines, p. xxiv.)

Community Colleges, and Technical And Further Education Colleges (T.A.F.E.). (Australian Community Colleges, 1979, p. 8).

The changes proposed in this, the policy statement of the Australian nursing profession, were an attempt to progress from what is described by Congalton (1977, p. 182-3) as the hospital-based "learning from service (ineffectively) programme" of nurse training, to the college-based "learning for service (effectively) programme".

During the transition to tertiary institutions, hospital-based schools of nursing were to be gradually phased out, as were post-basic infant and child care and community health nursing programmes, the rationale being that comprehensive tertiary level nurse education would better prepare the nurse for his or her role in the community and hospital alike. Post-basic nursing programmes presently follow a basic nursing diploma (R.N.) course and offer a specialty certificate after a period of study which varies between specialty areas. For example, until the change to tertiary level education, (effective this year), the CHN was awarded a diploma in community health nursing following successful completion of a one year course at the College of Nursing Australia, W. A. Branch.

0.4 SETTING

Decisions to change the structure of nursing education ultimately rest with the Commonwealth government. A decision to move nursing education from hospital-based schools to tertiary education institutions has enormous budgetary ramifications for several reasons. Financial responsibility for nursing education must ultimately shift from state health budgets to the Commonwealth education budget. True cost analysis of the change includes a calculation of cost in terms of both capital and recurrent items, the costs of student allowances, and, in the initial period, the cost of additional recruitment to hospitals to replace those student nurses who would then be in colleges. Cost estimates must also be examined in a total social context, which includes consideration of the transfer to education of offsetting savings which would occur in the health sector, or consideration of offsets to the general revenue assistance to the states.

As there exists little accurate information on these

matters, most states have established a joint ministerial committee of inquiry to try to develop a more accurate picture of the situation, and to try to evaluate the widely divergent views about the timing and implementation of such a transfer. (Report of the Australian Education Commission Working Party on Nurse Education, 1984, p. 8).

At the instigation of Wendy Fatin, a nurse who is the federal Member of Parliament for Canning, W. A., the Caucus Social Policy Committee Working Party on Registered Nurse Education was established in 1984 to link the present governing party (the Labour Party), to the nursing profession. Ms. Fatin relates that the committee was established with the idea of bringing the Ministers of Health and Education into discussion with backbenchers in the government to decide policy on nursing education. To make decisions easier and improve communications, the committee invited a spokesperson from each nursing organisation and the national union (the R.A.N.F.),[3] to enter into discussion with representatives of the Commonwealth Tertiary Education Commission (C.T.E.C.), the federal commission responsible for post-secondary education in Australia. A joint statement in August, 1984 by the

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3. The R.A.N.F. is considered the national 'union' of nurses as it has affiliation with the Australian Council of Trade Unions (A.C.T.U.).

Commonwealth Ministers for Health, Employment and Education revealed that plans for a move to tertiary level nurse education had come to fruition. A transfer of registered nurse education to colleges of advanced education will begin in 1985, with the last intake into hospital based diploma courses in 1990, resulting in a system of all tertiary level registered nurse training by 1993. (The West Australian, August 25, 1984, p. 20).

Although policy decisions are made at the federal level, the degree and direction of educational changes are, in effect, decided at the state level, based on identification of existing needs and resources in the state. (Fatin, W., Personal Communication, April 27, 1984). In Western Australia, the college-based basic nurse education course at W.A.I.T. represents some 11.1 percent of total basic nurse education in the state, with the remaining 88.9 percent distributed among five hospital schools of nursing. The current number of equivalent full time students (E.F.T.S.) at W.A.I.T. is 143, compared to 1140 enrolments in hospital-based courses. An arrangement has just been completed between W.A.I.T. and one of the five hospital schools (St. John of God), to transfer that hospital's enrolments of approximately 40 E.F.T.S. to W.A.I.T. By 1987 it is planned to boost college enrolments by over 120 E.F.T.S., to approximately 260, representing about 20 percent of total basic nurse education enrolments.

(Australian Education Council, 1984, p. 6). At present, progress toward that end is delayed, as members of the nursing profession await the results of efforts to finalise agreements for cost-sharing between the State and Commonwealth governments. Clearly, as of 1984, the issues of how, where and for what duration to educate the nurse are moving closer to being resolved in Western Australia.

Prescriptions for educating the Australian nurse cannot be imported from abroad, as the political, economic, social and geographic determinants are uniquely Australian. Ideologies, according to Draugsvold (1979, p. 47), "penetrate educational practice." The Australian nurse voices a resistance to the rigid hierarchical stratification of existing nursing education and practice, but the present style of nursing education prevails for reasons bound in culture. Firstly, isolation inhibits the cultural interaction necessary for experience with and exposure to alternatives. Secondly, political and pecuniary power supersede professional power. Economics preserves the dominant cultural operations. Change is costly and competition for the health dollar could precipitate power struggles and further divisiveness. Thirdly, educational experience has solidified roles, particularly in an educational climate "aimed at creating leaders and gentlemen of character." (p. 47).

Finally, the language, rituals and symbols have preserved the professional identity from within the ranks of nursing.

One cannot, therefore, generalise educational experiences to or from one or another culture. McFarlane (1970, p. 38) agrees, relating that a series of quantitative studies of content of nursing in Britain and North America have shown that "the nursing tasks are different in these two cultures and thus the criteria developed in one country should not be transferred to another." It is anticipated that, in attempting to imply meaning from the context and vantage point of the practising CHN in Western Australia, the result will be development of a curriculum which will, as Benner (1980, p. 309) suggests, be 'synthesized' and tailored to the needs of those practising in such an environment currently and in future.

0.5 STATEMENT OF THE PROBLEM

Consensus on the educational preparation of the CHN will remain a remote possibility until the competencies expected as outcomes of that education are identified. To date, little documented evidence exists detailing the number and type of tasks which comprise the daily performance requirements of the CHN, or of the adequacy of educational preparation for task performance. Specific sources of educational needs have not been analysed, nor has there been systematic investigation into preparation for decision-making and the effects of contextual elements on implementation of decision-making skills by the CHN. Enquiries directed at those currently on the forefront of nursing education research failed to reveal ongoing investigation of the area. Dr. Patricia Wood, Assistant Director-General, Nursing Branch, Department of Health, Canberra; Dr. John McArthur, Australian Education Council; Joan Bottorff, Senior Lecturer, Phillip Institute of Technology; The Research Officer, The Canadian Nurses Association; Robyn Tamblyn, Consultant, Nursing Service, Manitoba Association of Registered Nurses, were among those who replied to correspondence regarding current performance-based

research into community health nursing education. All affirmed the need for such research, but had no knowledge of current studies addressing the subject. There is, however, documented agreement by community health nurses in Australia of the need for further knowledge and skills for adequate task performance in the practice setting, particularly in the rural areas. (Hurworth, Cox & Marston, 1976, p.76; Ranse, 1976, p. 8; Hudspeth, 1977, p. 12; Archer, 1977, p. 53; Munoz & Mann, 1982, p. 28.)

0.6 PURPOSE OF THE STUDY

It is the purpose of this study to explore the competencies which comprise the role of the CHN by investigating her or his daily task performance requirements. Interpretation of discrepancies between the nurses' education and service roles will allow a curriculum to be logically derived with an orientation toward the realities of the practice setting. It is anticipated that the study will yield information useful for present and future coordination of community health nursing activities, and ultimately, will elevate the profile of this specialised group of nurses both within and external to the profession.

0.7 OBJECTIVES

The study will investigate several specific objectives:

1. A competency-based curriculum for educating community health nurses will be developed, based on analysis of the information provided by those currently working in the field. The participants will be asked to make judgments on both adequacy and source of their individual educational preparation for task performance.

2. Information provided by the CHN will be used to clarify the relationship between education, experience and task performance.

3. The instrument to assess task performance of the CHN will be designed to discover the extent of decision-making in the daily activities of the CHN.

4. Existing educational efforts in the preparation of community health nurses will be evaluated. The present curriculum as preparation for task performance and the methodology of its presentation will be examined.

5. The instrument will be developed with the intention of its having utility for further research in nursing education.

6. Information regarding the practice activities of the CHN will be communicated to nursing leaders to supplement their information on education and task performance of this group, and to aid in recruitment and planning strategies for community health nurses.

7. It is expected that participation in the study will raise the self-consciousness of the CHN in regard to individual professional activities with the aim of improving his or her documentation.

0.8 ASSUMPTION

The study is based on the assumption that task performance requirements of the CHN have specific educational and/or experiential prerequisites which can be identified and defined. A comprehensive curriculum could provide for a select number of those performance requirements. This curriculum will include pre-service and continuing components; the latter containing self-initiated, (study, reading) and other-initiated, (supervisor, peer, system-initiated) components.

0.9 DELINEATION OF THE RESEARCH PROBLEM

Community health nurses in Western Australia practise as employees of a health agency, such as the Silver Chain Nursing Association, or the Extended Care Nurses division of Hospital and Allied Services; or within Community and Child Health Services (C.&C.H.S.), a division of the Health Department of W.A. One group of nurses within C. & C.H.S. are called community nurses, or field nurses. They are community-based nurses who conduct individual, family and group activities for health maintenance, improvement and/ or restoration in the home, community center or other appropriate areas of the client's environment. These nurses also serve as clinical instructors supervising the field education of Aboriginal health workers. Child health nurses are another group of community-based nurses who focus on parent education and support, health surveillance and prevention of illness. A third group, school health nurses, combine teaching, health appraisal and health maintenance activities in schools or school districts. (An elaboration of the role of the school health nurse in Western Australia is provided by Samuels, 1980.)

Community health nurses are assigned to regional divisions, either urban: metropolitan Perth, or rural: South-West; Eastern Goldfields; Central; Pilbara; or Kimberley. The regions are similar, but not identical to statistical divisions (see Fig. 2, 3).

In addition, some community health nurses assume the role of outpost nurse, practising as the sole health care professional providing for the needs of a community, often with the assistance of one or more Aboriginal health workers. A group of highly specialised nurses also practise within C.&C.H.S., each having a unique function. Examples include the nurses attached to the Royal Flying Doctor Service, referred to as field nurses (flying); school resources nurses; children's daycare nurses; the youth health services community nurse; the independent living centre nurse; correspondence nurses; and epidemiology nurses. In addition, several department nurses are jointly responsible to C.&C.H.S. and a foundation within which they operate; such as the community nurse - diabetes; the community nurse - VD; the eye health and trachoma programme nurse; the Hansen's (leprosy) nurse; and community nurses for rheumatoid arthritis, multiple sclerosis, muscular dystrophy and lung organisations. Staff development nurses are employed by the Health Department, but in a division separate from C.& C.H.S., to provide for continuing education needs of all the

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Figure 2:

NOTES

1. Bases in the Metropolitan Region have not been marked.
2. School and Child health nurses are based in many major towns (not marked).
3. Centres are used as bases for mobile work, areas up to 250 kms distant are covere regularly by road.

Figure 3:

WESTERN AUSTRALIA

STATISTICAL DIVISIONS

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above nurses as well as other staff. Occupational health nurses (O.H.N.) are another separate group of community health nurses, being employed by the individual company on whose premises they work to meet the health needs of employees.

Urban nurses and some rural nurses are therefore designated according to employer and functional specialty. Other rural nurses are designated according to location and may function in a multiplicity of roles depending on the size and needs of the community, and their own expertise.

Placement of community health nurses is determined by manpower requirements and educational preparation of applicants. For each CHN employed by C & C. H.S., one year's post-registration experience is mandatory. For the generalist role of a rural field nurse, essential requisites include post-basic midwifery certification, an orientation to the needs of what are predominantly Aboriginal communities, and desirably, a post-basic certificate in community health nursing.

At present, the nurses employed by the Health Department come from a broad range of educational backgrounds, holding qualifications from several countries and from the various states of Australia. The courses leading to their credentials are variable and their experiential backgrounds are widely diverse.

In practice it is unknown which nursing behaviours are contributing to client outcomes or which functional categories of CHN are employing particular strategies in nursing care. It remains to be determined whether differences in educational backgrounds of nurses working within one or another subspecialty group are related to either the quantity or type of tasks which they are performing, or whether differing educational and/or experiential backgrounds precipitate differing levels of autonomous decision-making in practice. Further, it is unknown what effects the varying contextual constraints impose upon the nursing care delivered in any of the community health settings.

Investigation of the nurses' opinions on their task functions and individual educational and experiential preparation will provide insight into these questions. This enquiry will take the form of a survey of as many currently practising Western Australian community health nurses in as many functional categories as possible, as time and financial restraints allow. Interpretation of the replies of community health nurses to queries on task performance and educational/experiential preparedness for task performance will provide the basis for a synthesized curriculum with both pre-service and in-service components, devised to meet the specialised needs of

these and future community health nurses.

0.10 IMPORTANCE OF THE STUDY

The core of uniqueness of the CHN is, according to Archer & Fleshman (1975, p. 358), her or his "breadth of knowledge and expertise." Australian registration statutes contain no definition of the scope of nursing practice which is currently determined by the nurse's training and the employer's usual practice, rendering analysis and generalisation of the role difficult. (Roemer, 1972, p. 68). Community centred practice is often distanced from educational and health care institutions, rendering post basic education more difficult to obtain than for nurses in hospital-based specialty areas. Consequently, many community health nurses are under prepared for the role. According to 1976 Michigan Department of Public Health Statistics, the majority (61.3%) of community health nurses practising in that state are not prepared in community health nursing. (Keller Beach, 1982, p. 29). Hurworth, Cox & Marston's 1976 study of nurses employed in Australian community health centres concluded that 50% (25 nurses) had no particular qualification for community health nursing. (p. 75). It is unknown how

representative a statement this is, and if it is the present state of education of the CHN currently practising in Australia.

Given the medical profession's legally supported monopoly over health care, Williams (1977, p. 176), using medicine's expression for comparative research into the relative advantages of one clinical technique over another, suggests that "nurses must conduct their own 'clinical trials'" to validate selection of one or another educational programme. Only in this manner will nursing ultimately achieve status as a true profession, that is; demonstrating "committment, development of a distinct body of knowledge, educational process, autonomy and colleague control, and evidence of a vital social service." (Duespohl, 1983, p. 12). To build what Gortner, Bloch & Phillips (1976, p. 23) refer to as a "science of practice" is the first step towards "self-regulation and control over role function", which Murray & Morris (1982, p. 311) deem a necessity, if the CHN is to function as a true collaborator in community health care. Description of this science of practice will serve the needs of nurses, the needs of educators and the needs of health manpower planners to assure the "fit between the output of educational systems and the manpower needs of health services." (A Community Health Program for Australia, 1973, p. 5).

0.11 SCOPE AND DELIMITATIONS OF THE STUDY

A thorough and comprehensive study of the task performance requirements of the CHN would include nurses practising in all specialty areas, in all locations within the state, and in defined comparative settings. The present study is limited by resources and the distances which separate the CHN from the research location. A further limitation is the time constraint, which, if eliminated, would allow a time series study to validate whether the task performance evaluation days were truly representative of an average or 'usual' day. A time series study would also add to the response burden of this group of nurses who are inundated with requests to participate in a variety of research studies from colleagues pursuing health sciences courses at W.A.I.T.

A large number of community health nurses (412), practise within the Health Department in W.A. Survey forms will be mailed to 376 of these. Excluded will be the Health Department and private agency nurses who work in such highly specialised functional categories as to render their responses to the survey interesting,

but not generaliseable. Further, the effort to collate and analyse a larger number of responses, given the comprehensive nature of the survey, would be beyond the scope of this study.

0.12 REMAINDER OF THE THESIS

Chapter two of the thesis explores the literature related to the investigation. Historical developments pertinent to nursing education in Australia and abroad are related, and studies addressing educational preparation for the current and future role of the community-based nurse are described. Studies outlining experiences with a variety of nursing education systems, techniques and media are then reported, and a brief summary is presented in review. Chapter three describes the methodology and procedures followed in conducting the survey of tasks performed by community health nurses, summarised at the close of the chapter. In chapter four, analysis and interpretation of the findings are presented in the context of answering the research questions posed, and chapter five summarises the general study content, presents the conclusions and discusses the recommendations on programme planning for the educational needs of the CHN.

CHAPTER TWO

REVIEW OF RELATED LITERATURE

This chapter is intended as an examination of the literature which guides the investigation. The first section outlines historical developments which situate the need for this line of enquiry at this time. Secondly, studies addressing education needs for the current role of the CHN are related. Finally, prescriptions for the educational preparation of the CHN are explored.

0.1. HISTORICAL DEVELOPMENTS

0.1.1. Nursing Education in Australia

Throughout the past quarter century, Australian nurses have sought to substantiate their conviction that hospital-based apprenticeship training should be replaced with education in tertiary institutions, through referral to both international studies and the growing body of Australian nursing education research.

The scheme of locating an appropriate level of nurse education programme within tertiary education institutions has steadily gained a committed following since first being suggested in Western Australia in 1935. (W. Gardiner, in Hobbs, 1980, p. 1).

The first baccalaureate level nursing course in Australia was conducted in 1976 at the Western Australian Institute of Technology. It was a two year (U.G.1) course for senior Registered Nurses. With some student nurses already placed within tertiary institutions, in 1977, the Commonwealth Ministry of Education announced a committee chaired by Dr. S. Sax:

> "To inquire into and make recommendations to the Tertiary Education Commission on possible developments and changes in nurse education and training, including whether such education should take place in hospitals, or education institutions, or both." (Nurse Education and Training, 1978, p. 3).

The Committee's report, commonly known as 'The Sax Report', cited fourteen previous reports dealing with the upgrading of basic nursing education which had been published between 1943 and 1977, observing common support for: full student status with education divorced from employment for student nurses; basic nurse training to be provided in educational institutions (limited support); post-basic education

to be provided in Colleges of Advanced Education or Universities; higher minimum entry standards; closer relationships between theory and practice; elimination of small hospital training schools; student nurses to be supernumerary during their clinical attachments; opportunity for each nurse category to progress to higher grades and formal training for nurse-aides. (p. 14). The Sax Report recommended changes philosophically aligned with nursing goals, including tertiary-level education for the professional nurse, but suggested a flexible, cooperative approach to the blending of hospitals and educational institutions, urging that: "change should be introduced cautiously and validated step by step." (Nurse Education and Training, 1978, p. 77).

In 1980, the Commonwealth Government announced limited acceptance of the Sax Report recommendations and announced an increase in the number of places for nurses in colleges of advanced education, to bring the total to 1200 by 1983. (Goals in Nursing Education, Review, 1982, p. ii). In 1984 the Commonwealth Tertiary Education Commission recommendation was for a further increase of 1000 places by the end of the 1984-87 triennium. Western Australia joined the other state branches of the R.A.N.F. in refusing to accept

the recommendation, and struck a working committee to lobby for a move to relocate all basic nursing education in tertiary institutions by 1990, with a progressive phasing out of hospital-based basic training in the interim. (McKenna, B., R.A.N.F. (W.A. Branch), Personal Communication, June 11, 1984). The outcome of endeavours toward the move to 'all tertiary' basic nurse education is manifest in the announcement cited previously, that the Commonwealth Ministers for Health, Employment and Education intend to legislate a total transfer of basic registered nurse training to colleges of advanced education by 1993.

0.1.2 Nursing Education in New Zealand

Nursing education in New Zealand has evolved from events bearing historical similarities to those which have occurred in Australia. (Shadbolt, 1983, p. 6). The New Zealand Carpenter Report of 1971, preceded the Sax Report in recommending a gradual transfer of basic nursing education from the hospital-based to the college-based system. (Carpenter, 1971). The report represented the culmination of a 1970 study tour of New Zealand nursing education systems, conducted by Dr. Helen Carpenter, on assignment from the World Health Organization (W.H.O.) as an expert consultant to the

New Zealand government. The critical issue dealt with in her study was whether nurses in that country could continue to be prepared on an employee basis. Her report unequivocally recommended that "preparation for service should precede acceptance of responsibility and that registration, signifying a minimum standard of safe practice, should precede employment." (Shadbolt, 1983, p. 8).

New Zealand has subsequently witnessed a decade of transition from hospital-based to college-based nurse education which is still incomplete despite the existence of eleven comprehensive basic nursing courses offered in technical colleges. In 1983, for the first time, the number of students entering the college-based programmes, (called 'student-based' programmes in that country), has surpassed the number entering hospital-based programmes. A major impediment to the wholesale transfer of nursing programmes from hospitals to colleges is explained by Shadbolt (1983, p. 7) as the fact that "the impetus and power for change was vested in the same nurse leaders who must then cope with the consequences of a diminished and diluted workforce". If the New Zealand experience is to serve as an example for an Australian transition to the college-based system, the expectation that it will be "slow, gradual and hard won" would serve as a realistic

cautionary sentiment. (Shadbolt, 1983, p. 7).

0.1.3 Levels of Nurse Education in North America

In North America, where basic nurse training has been offered at both hospital schools of nursing and tertiary institutions since 1910 (Draugsvold, 1979, p. 47), endless debate is reflected in studies which outline the relative capabilities of graduates of one or another of these basic programmes. (Davis, 1972, 1974; Sheahan, 1974; Pankratz & Pankratz, 1974; Hover, 1975; Hogstel, 1977; Nelson, 1978; American Nurses' Association, 1978; Curtin, 1982).

Several studies have suggested methods for implementing long term planning for changing educational requirements through articulation. (Cobin, Traber & Bullough, 1976; McCulloch, 1979; Fitzpatrick, 1981). A student could conceivably articulate through the nursing strata from a common base of knowledge with each acceleration adding a credential, further responsibility, greater status and increased monetary reward. For example, a nurse-aide (N.A.) could progressively add-on to his or her curriculum to be designated a licensed practical nurse (L.P.N.), then an associate diploma nurse (A.D.N.), then a registered

nurse (R.N.), then a master of nursing (M.N.); such graduated categories typifying the credentialling process for nurses in the U.S. and Canada.

This type of system allowing articulation to higher levels is attuned to the philosophies of Houle (1973), and Knowles (1975). One could agree with Bullough, Bullough & Soukup (1983, p. 240) that, as Houle and Knowles propose, it is important to recognise flexibility, recognition for prior learning, and diversity in teaching and learning as essential needs of the adult learner. Articulation makes allowance for these needs.

Kramer (1974, p. 226) argues against articulation on the premise that maintaining the distinction between the technical and professional nurse would better serve the needs of both client and nurse. She describes the essence of the professional nurse as "the fact that she consistently and constantly sees and nurses the individual and family as a whole entity. This total, comprehensive view of the individual is first and foremost. From this flows all other characteristics." This, somewhat elitist, view could be interpreted as implying that the technical or auxiliary nurse maintains a task-oriented rather than client-oriented nursing practice. It could be argued that both levels of nurse practise within a comprehensive view of the

individual, the difference being the degree of decision-making allowed, as suggested in the Goals in Nursing Education statement (1976, p. 10).

0.1.4 American Nursing Education Programmes

Variation in programmes proposed in the United States include maintaining apprenticeship programmes (Curtin, 1982); offering a degree plus internship programme (Ackerman & Baisel, 1975); nurse practitioner programmes - degree programmes supplemented with medical assessment and behavioural sciences courses, (Andrews & Yankaur, 1971; Igoe, 1975; Archer & Fleshman, 1975; Demaio, 1979); paediatric nurse associate programmes, where the specialty course is added to an associate degree programme (O'Brien, Manly & Haegerty, 1975); open curriculum proposals, where choice of options would provide maximum flexibility and capitalise on previous relevant education and experience (Lenburg & Johnson, 1974); external degree programmes (Bullough, Bullough & Soukup, 1983); and external graduate degree programmes (Simms, in Duespohl, 1983) - both of the latter aimed at facilitating accessibility to education for the working nurse.

Such diversity of opinion from a country with a 74 year history of tertiary level nursing education contributes to the dilemma of choosing a relevant course to follow in Australia, where experience with tertiary level nursing programmes has all occurred within this decade.

0.1.5 Continuing Education

Despite differences of opinion on pre-service programme needs, there has been a great deal of emphasis placed on the need for continuing education. Support for this need to increase levels of knowledge and skills comes from nurses at the grass roots level (Robischon, 1971; Skipper & King, 1974; Haferkorn, 1975; O'Brien, Manly & Haegerty, 1975; Ruth & Partridge, 1978); from nurse educators (Davis, 1972, 1974; Calderon, 1979); from the medical profession (Richards, 1977; Legge, 1979); and from social scientists (LeBow, 1972; Dingwall, 1976; Murray, 1977; Mechanic, 1979). In addition, a journal, The Journal of Continuing Education in Nursing (JCEN) is devoted exclusively to the subject of continuing nursing education.

In the field of community health nursing, Australian

nurses interviewed by survey in the Hurworth (1976, p. 76) and Archer (1977, p. 53) studies, pointed to an overwhelming need for additional specialised knowledge. Outpost nurses in Northern Territory and South Australia, interviewed several years later reiterated similar needs as a necessity if they are to continue practising confidently as primary care givers. (Munoz & Mann, 1982, p. 28).

Against a background of consensus on educational need but procedural uncertainty, nurses have sought to relate the educational experience to its purpose, and to simultaneously elucidate the role which it is to facilitate.

0.2 EDUCATION NEEDS FOR THE CURRENT ROLE OF THE CHN

0.2.1 The Role of the Nurse

From within the profession, the volume of published exploration into the nursing role is testimony to its elusiveness. The urgency to clarify the role of the nurse is underlined by those who recognise the task of delineating nurses educationally and coordinating them functionally. Researchers in the United Kingdom (McFarlane, 1970; Anderson, 1973), in North America (Mussallem, 1969; Ingalls & Salerno, 1979; Felton, 1980), and in Australia (White, 1972; Frith, 1975; Draugsvold, 1979; Patten, 1979; Brann, 1980; Furler, 1982; Brewer, 1983), have made valiant attempts at concise definition of the role.

0.2.2 Historical Evolution of the Role

Florence Nightingale conceptualised the nursing role as an extension of the traditional female role. (Bullough, Bullough & Soukup, 1983, p. 4). She fostered in her nurses a subservient, nurturing, care-giving tradition, yet claimed that the term

'nursing' "ought to signify the proper use of fresh air, light warmth, cleanliness, quiet and the proper selection and administration of diet - all at the least expense of the vital power to the patient". (Nightingale, 1859, p. 6).

Since the turn of the century, the role has expanded to demand a degree of caring equivalent to the days of treating the war wounded, retaining the helping relationship characteristics of "non-possessive warmth, genuineness and accurate empathy" (Sorenson & Luckmann, 1979, p. 31), but from a greatly increased and diversified knowledge base. Tiffany (1979, p. 4) distinguishes a nursing model related to 'care' from the medical model related to 'cure'. Nursing generally, and community health nursing particularly, takes place within the environment of the client. Medicine can be practised away from that setting with disease as an entity. The emphasis of nurse educators must shift from 'cure' to 'care', in order to nurture a generation of graduates skilled in teaching the concepts of self-care, in line with the global strategy of 'Health for All By the Year 2000'. This strategy was a request of the 1977 Thirtieth World Health Assembly which resolved that the main social target of governments and the World Health Organization in the coming decades should be "the attainment of all citizens of the world

by the year 2000 of a level of health that will permit them to lead a socially and economically productive life." (W.H.O., 1979, p. 7).

0.2.3 Education for Role Requirements

Suggestions for requisite educational inputs include interdisciplinary studies components. The nurse of today must rely on the social sciences to understand what Brewer (1983, p. 36) describes as a role which "oscillates between the formal role required by the system and the informal role required by the client/consumer."

The distinction between 'caring' and 'curing', Brewer proposes, assumes an added dimension against the changing technological environment: "Instead of the steady rate of functional interchange, technological change may have catapulted the nurse into the technical area without meaning, training or education."(p. 36). The hazard here is that of inadvertent regression of the nurse to the safety of traditional roles.

The situation is underlined by David Legge (1979, p. 44) who contrasts the training of medical students by those "academics practising and developing the growing edge", to nurse training schools which have been "a

backwater slow to respond to technological developments and frequently [teach] concepts that have diminishing relevance to what is being practised." He posits that "educational and service policies which are developed in conflict between competing professional groups can only reflect the relative strengths of those groups, not the needs of patients or community." (p. 45).

Barriers to assimilate the new technology have come from within the profession. Rapid escalation of the need for nurses, increased knowledge needs responded to by increased levels of education, broader occupational choices for women and increasing awareness of discriminatory practices have led nurses to a "sense of 'frustrated entitlement'." (Bullough, Bullough & Soukup, 1983, p. 9-10).

The women's movement has had profound effects on nursing education from the perspective of labour studies. Trend analysis suggests that in future, nurses will devote more time to their profession. A predominantly female profession, (90% according to Nursing Personnel: A National Survey, 1979), nursing draws from the larger proportion of students proceeding to higher education. By 1980, more Australian females than males, having completed year 12, proceeded to higher education. (Learning and Earning, 1982, p. 154-55). A survey of nursing manpower in 1981, (Western Australian Public Health Department, 1981),

determined that 9991 nurses were employed in W.A. in that year. At the national growth rate of 5% per annum (according to the 1979 national nursing personnel survey) there would be upwards of 10,000 currently practising in W.A. According to projections cited by Price and Mueller (1981, p. 4), more nurses in future will remain single, and married nurses will increasingly expect to continue in their profession either to fulfill themselves, or to supplement the family income. The 1979 nursing personnel survey revealed that 65% of nurses registered in Australia were employed in nursing that year, reflecting, in part, the fact that separated or divorced nurses continue working as heads of single-parent families. (Price & Mueller, p. 4).

"Relevant, recurrent education" as suggested by Brewer (1983, p. 95) is therefore vital to the nurse's coping with an extended and expanded role. Not only must that role evolve in step with societal change, but it must be defined according to its performance requirements and educational inputs must correspond in a dynamic, flexible way. Educators must shift emphasis from planning for immediate tasks to those which prepare for life-long professional function.

In the future, nurses in administration will probably require management skills to function as middle

managers within the institution. It is likely that teaching skills will be essential for all nurses. The nurse will, according to Sheahan (1974, p. 26) "practice more knowledgeably and confidently supported and invigorated by a firm and elaborate body of knowledge". Sheahan suggests that in the process of socialisation to an expanded role, the nurse will "internalize professional values, norms and beliefs that will guide her from within", and she will "thus exercise greater autonomy." (p. 26).

The challenge for those devising educational curricula for the nurse in such a constantly changing work environment is one of maintaining balance between the needs of nurses and the needs of their consumer/client population.

In 1983, the Australian national nursing organisations, (R.A.N.F., College of Nursing, Australia, Florence Nightingale Committee, Australia), demanded that by 1990 "all basic nursing programmes shall be comprehensive in nature and conducted in higher education institutions at undergraduate levels; adequate numbers of post-registration programmes shall be available, including some at post-graduate diploma (PG1) and master's degree (PG2) level in colleges of advanced education; and effective continuing education programmes shall be available to all nurses." (Qualified Nurses for Qualified Care, 1983, p. 1).

Such requests for upgrading the levels of education suggest that from the nurses' point of view, educational needs are not being adequately met in the present hospital-based apprenticeship system of nurse training. Researchers studying graduates of the Australian tertiary level nursing programmes conducted thus far have attempted to evaluate the education as it translates to performance in the hospital setting.

0.2.4 Performance Studies

Australian studies of competence in graduates from hospital diploma level and college degree level nursing courses have demonstrated that nurses from the two programmes have similar competencies which vary under differing environmental conditions (McArthur, Brooke & Bruni, 1981; McArthur, Walsh & Bruni, 1983), evoke equivalent self and supervisor ratings of perceived competencies (Lonsdale, 1980), and possess similar intellectual capacity with differing attitudes attributable to increased education (Orb, 1982).

All four studies, as those of American researchers (Fredrickson, 1977; Alexander, Weisman & Chase, 1982) have concluded that contextual factors present the most important determinant of performance. "Performance is

a combination of ability, opportunity to display competencies and the influence of organisational climate." (Lonsdale, 1980, p. xii). McArthur, Brooke & Bruni (1981, p. 15) suggested that when supervisors and graduates provide ratings of graduates' performance in the practice setting, "differences may be explained in part by differences in expectations of the supervisors and graduates, which, perhaps, reflected differing beliefs and standards of performance." In the teaching hospital, that environment familiar to the hospital-trained nurse, hospital graduates consistently outscored college graduates in measures of skills in interpersonal relationships, procedures, professional competency, health education, safety, confidence, sensitivity, concern and efficiency. In non-teaching hospitals, the college graduates consistently outscored hospital graduates on these measures, leaving the authors to conclude that a higher level of confidence and adaptability are characteristic of college graduates who have experienced a variety of clinical settings. If this is a valid conclusion, college-based education should better equip the nurse for the community health role, where high levels of self-confidence and adaptability are necessary prerequisites for the relative autonomy, or independent functioning, demanded in the practice situation, particularly in rural settings. To assess actual

autonomy, (defined by Murray & Morris, 1982, p. 311, as self-regulating control over role functions in the work situation), as distinct from theoretical autonomy, an evaluation of decision-making in task performance of the CHN is necessary.

0.2.5 Decision-Making in Nursing

Decision-making has been described by Shaefer (1974) as the art of choice following deliberation and judgement. The Claus-Bailey Model for Decision-making calls the same sequential process 'search-analyze-choose'. (Bailey & Claus, 1975, p. 7). In Shaefer's opinion, decision-making demands that three conditions be fulfilled: freedom, rationality and voluntarity. Rationality is the culmination of deliberation (careful thinking), and judgement (an authoritative opinion): the greater the deliberation and judgement, the more rational the decision. (Shaefer, 1974, p. 1854).

Lamonica (1979, p. 238) expresses decision-making as a function of leadership. To the client, the nurse is a recognised leader, expert, or authority; thus decision-making is ascribed to the role. In addition, Janis (1982) refers to the "referent-power concept in

explicating the facilitating type of affiliative bond between the client/patient and the health care professional. The...client feeling of 'acceptance' by the professional bestows the power of leadership on that professional." (p. 197).

Decision-making pervades the entire nursing process. Freedom is at least theoretically provided for in the community health nursing situational context. Rationality is the product of a nursing education which emphasizes deliberation and judgement and the nurse's experience as client advocate. Change, or the voluntary search for change, is the element which gives momentum to the operation of decision-making. (Shaefer, 1974, p. 1854).

0.2.6 Knowledge, Decisioning and Performance

The decision-making process and the nursing process are interrelated cyclical activities with the client as active agent involved in decisions. When these processes take place in a group, increased coordination is necessary. The CHN must closely monitor decisions made not only at the client-provider encounter level, but at the aggregate level where groups, or aggregates of individuals select themselves into the care system.

Williams (1977, p. 251) describes the function in such cases as demanding a public health orientation where attention must be paid to multiple and sometimes overlapping aggregates. This, according to Williams, demands "specialised skills which are an appropriate mix of techniques drawn from measurement and analytic sciences of epidemiology and biostatistics; social policy and the history and philosophy of public health; and principles of management and organisation for public health." (p. 253).

These educational correlates to the performance requirements of community health nurses represent an adjunct to basic nursing education. Inherent in the role of the CHN is the knowledge that, as the primary health care provider, decision-making is often carried out in isolation and with ultimate responsibility for outcomes. In the hospital setting, decision-making is no less purposeful, but the backup provided by a hierarchically arranged network of professionals offers reassurance and occasional respite from the stress of high levels of responsibility. The primary care nurse in any setting must function as a manager within the health care team, at the nexus of both vertical and horizontal decision-making. Nurses in primary care situations require "effective systematic reasoning" as one of their most powerful tools in client management.

(Bailey & Claus, 1975, p. 10).

To devise a curriculum to adequately prepare a specialist nurse-manager for the community, essential role competencies must be determined. Brann (1980, p. 46) describes the need to formalise evaluation of community health nursing performance in Western Australia as "urgent", formal evaluation having thus far been impeded by the lack of clear cut definition of the [CHN] role and function, and the diversity of agencies using nurses in a variety of ways. (p. 46).

Support for the dilemma of imprecise role definition was echoed by Koerner in a 1981 study of community health nursing job performance. Supervisor ratings "raised more questions than they answered." (p. 48). Difficulties included objectivity of supervisors, such intervening contextual variables as the time allowed for documenting performance and the accuracy of that documentation; typifying the problems of research into a discipline with clinical rather than cognitive objectives. Tools must be developed to evaluate a profession which, until now has been "almost entirely founded on personal wisdom rather than scientific conclusions." (McClure, in Duespohl, 1983, p. 25). The present study therefore intends to examine self-reported role requirements rather than those once removed from actual role performance.

0.3 EDUCATIONAL PREPARATION OF THE CHN

0.3.1 Requirements Related to Function

In an attempt to design a curriculum that addresses the needs of Australian nurses, it is helpful to examine other locations facing a similar task.

Frith (1975), in a New South Wales study of nurses working with Coasttown Aborigines, and Munoz and Mann, (1982), in a survey of training needs of nurses in the outback of Northern Territory and South Australia, suggest an examination of exemplary programmes in Canada, where nursing is also practised in isolated outpost settings. The Clinical Training for Nurses (C.T.P.) programme was introduced in 1971, following evaluation of Canadian outpost nursing education needs, and included criteria upon which relevant education programmes were to be devised. (Munoz & Mann, 1983, p. 2). A nine year longitudinal study by Hazlett & Edwards, (1981), showed consistently higher levels of practising ability among course participants compared to nurses who had no such training. (Munoz & Mann, 1982, p. 3).

The role of the outpost nurse in Australia extends to preventative health measures, rehabilitation and psycho-social aspects of health care, diagnosis and clinical management of medical conditions, and an understanding of Aboriginal culture. (Ranse, 1976; Hudspeth, 1977; Munoz & Mann, 1982, Nathan, 1983). The nurses surveyed by Munoz & Mann also divulged that their confidence in practice correlated positively to length of experience, citing "trial and error" and "reference books" as how learning occurred by experience. (p. 27). At present, preparatory training for nurses working in the outposts takes the form of orientation and in-service courses provided by the employing agency. These vary in length from three days to two weeks and the content varies between states. Additional specialised preparation was identified as a necessity by 96% of the 115 nurses surveyed by Munoz & Mann.

The Australian community field nurse strives to assist community members attain and maintain their own perceived optimal level of functioning, through a process of counselling and education.

The role of the present day maternal and child health nurse in Australia, referred to in W.A. as 'child health nurse' is similar to that of her or his American

counterparts. Required is:

> "An understanding of the reproductive process, its possible complication, care of the mother and her growing child in health and illness, an ability in health teaching, an appreciation of the role of the family and a knowledge of community resources." (Ingalls & Salerno, 1979, p. 9).

The school health nurse is the vital element in promoting wellness in the school enviroment, and, similar to the American school health nurse described by Medaris (1967), and Egbert (1980) he or she provides a pivotal link between the family and adequate health care.

Such are the nurses who provide health care in the spirit advocated by WHO, in the Declaration of Alma Ata, adopted Sept. 12, 1978, by the International Conference on Primary Health Care. This conference, jointly sponsored by WHO and UNICEF, issued the challenge to provide primary health care "where the people are, where they live and work and where health care is provided in the spirit of self-reliance and self-determination", clearly stating that primary health care is the key to 'Health for all by the Year 2000'. (WHO Formulating Strategies. 1979. p. 7). Following from this self-care philosophy, it remains the penultimate task of the CHN to facilitate "community competence." (Goeppinger, Lassiter & Wilcox, 1982, p. 464). This objective is adhered to by

the Western Australian community health nurses who propose to "protect and promote the health of the people of W.A." in a set of goals grounded in the philosophy of self-care. (Health Department of W.A., Planning and Review Section, 1984).

0.3.2 Curriculum Development

Implicit in the self-care philosophy, is an orientation toward wellness, rather than illness , precluding educational programmes which would retain existing institutionally-focused (hospital-based) curricula. Skills in assessing and acting upon what Orem (1980, p. 39) refers to as an individual's therapeutic self-care demand, are a relatively new addition to nursing curricula. The query must then be raised as to whether to provide a broad, generalist orientation to community health nursing in undergraduate programmes with specialty components added at postgraduate level; or to provide specialisation at undergraduate level, as suggested by Hipps (in Duespohl, 1983, p. 112), with the generalist orientation provided at postgraduate level. Either choice presupposes inadequacy in the duration of present curricula as, according to McFarlane (1984), nursing curricula continue to retain the core

curriculum elements such as anatomy and physiology and compound these with recently identified necessary components. One result of this has been a subtle shift to increased rather than redirected education.

Caution against the 'more is better' trend in nurse education was first issued from a 1926 North Carolina (U.S.) Public Health Department study related by Mongeau, Smith & Maney (1978, p. 141-42). These authors related a study of 'Granny Midwives', half of whom were illiterate, which demonstrated that both the literate and illiterate cohorts performed the midwifery function equally well.

Smith (1980, p. 34) corroborates the priority of relevancy, rather than quantity in programme planning:

> "To obtain and insure the professional status of nurses we are told that we must demand continued and higher education...There are some flaws in the line of reasoning which concludes quality of patient care from higher education."

Fields (1980, p. 21) criticizes the pressure placed on American nurses to upgrade their nursing credential to baccalaureate status, speculating that this movement has contributed to the coffers of colleges rather than to the advancement of nursing.

A further issue on curriculum development is reviewed by Hipps (in Duespohl, 1983). She stresses the need for

'correlated' rather than 'integrated' curriculum content, charging that, in the 60's, "while most disciplines sought to present themselves as highly developed specialties, nursing elected to reach back to the 1930's and 1940's to the progressive education era, to develop a curriculum that purported to emphasize the whole rather than the parts." (p. 107). This refocusing of priorities, in her opinion, has caused oversight in attending to immediate requirements rendering client care less effective. The premise is, therefore, that highly integrated curricula cannot adequately prepare for specific nursing care encounters. Archer, (1982), agrees, suggesting that integration is a useful concept except when it results in obliteration. She elaborates that:

> "If everyone teaches a small bit of something, it seems that soon, no one teaches anything about it at all. Eventually students cannot recognize what is being taught, much less how it differs from something else (p. 443)."

Davies (1982), in a questionnaire survey of students completing the community health nursing module in basic nurse training in Nottingham, England, lends support to this argument, concluding that "the change in organisation from a self-contained module to integration with other units of learning has been shown to be undesirable in practice however laudable it may be in theory." (p. 91).

According to Hipps (1983), a curriculum must involve both analysis and synthesis, induction and deduction. The integrated curriculum model appears to call primarily for deduction. She suggests that to nurture problem-solving skills, instead of saying, as we do now, "Here is a concept; see how many phenomena you can locate to demonstrate the concept," perhaps we should just as often say, "Here is a set of phenomena; what generalizations, if any, can you draw from them?" (p. 112).

The W.H.O. community health nursing committee prescribed in 1974 that the community health nursing curriculum should aim for the following:

> "A curriculum that is people oriented not institution-centered and that emphasizes health rather than disease. Such a curriculum would produce graduates with knowledge of the basic and behavioural sciences, with clinical skill in diagnosing illness and other deviations from health, both physical and emotional, and with the ability to prescribe preventative, curative and rehabilitative therapy. The graduate nurse would be able to adapt health care to the family and community setting, using medical and other referral services for the greatest benefit to the patient." (p. 18).

A curriculum aimed at such a comprehensive generalist role is philosophically commendable. However, the spectrum of diversity within the existing Western Australian community health nursing role demands a more correlated, content specific programme to adequately

prepare for each functional category. If the generalist base is provided at undergraduate level, it would then remain for continuing education components to provide for subspecialty needs.

0.3.3 Continuing Education Curricula

Since a directive from the American Nurses Association (ANA) in 1971 that "education for community health nursing is continuing, not episodic", methods of continuing education have been the concern of a number of American community health nursing researchers. (ANA Standards of Community Health Nursing Practice, 1971, p. 4). Investigations have addressed continuing educations systems, techniques and media.

Systems of continuing education which promote self-directed learning are being established in many American centres. One such system is that of the 'Roving Inservice', which brings learning modules to Pennsylvania nurses in areas remote from the large teaching institutions. (Lescher & Bomberger, 1983). Similarly, workshops on interpersonal skills are being conducted throughout Iowa. (Friedrich, Scandrett, & Turoch, 1979). Self-learning packages have been developed and evaluated by occupational health nurses

and are considered a very valuable continuing education format. (Gilbert, 1983). Computer-assisted simulation programmes, though costly, have been used for self-paced instruction in community health nursing. (Schleutermann, Holzemer & Farrand, 1983). Zack Stein & Gerber Eigsti (1982, p. 32) report further potential from computer systems, in that, at Rochester School of Nursing in New York, a data base management system (D.B.M.S.) has been devised to systematically classify data about a community into a usable form, so that nursing diagnoses can be identified appropriately. Bullough, Bullough & Soukup (1983) propose independent study techniques in general, as a solution to continuing needs of both nurses in isolated areas and in working situations where time constraints and responsibilities prohibit attendance at an institution. These authors acknowledge learning methods suggested by Lenburg (1983), including "contract learning, personalized self-instruction, preceptorships, correspondence study, self-paced modular learning, a flexible-progress approach and other versions of independent study." (p. 240).

The techniques of presenting independent study programmes are currently being explored by nurse educators. Mediated instruction, the use of audiovisual materials, is advocated by Siegal (1982,

p. 8). She suggests that "pictures, color, and sound guide the learner to find the answer in her/himself. When this mode of delivery is coupled with programmed instruction, immediate feedback is provided through self-correction and reinforcement of correct behavior takes place."

Since 1977, 'Telehealth', a system of using satellite transmission as the medium for continuing education programmes for all health care personnel, has been implemented in remote areas of Northern Ontario, Canada. It has been described as being responsible for keeping the nurses updated on recent advances in health care, and sustaining a higher level of interest and participation in continuing education than previously. (Charbonneau, 1981, p. 22). In addition, baccalaureate level nursing courses are being delivered via satellite from the University of Victoria, to nursing students throughout the province of British Columbia, widening access to those who might otherwise not participate in university education. (Collins, 1982, p. 16).

In preparation for the launching of Aussat, Australia's first satellite, in July, 1985, a Western Australian Satellite Education Advisory Group (W.A.S.E.A.G.) has been formed to investigate educational uses for the satellite. The committee's activities include scrutinising Canadian satellite

programmes for both community and continuing professional education. The existence of a system of delivering nursing programmes by external studies, will undoubtedly prove to be useful groundwork should a satellite programme of nursing education be inaugurated. Five units of the Bachelor of Applied Science (Nursing) course at W.A.I.T. are available in 1984 on an external study basis. In the United States, some nursing degrees are obtainable entirely by external studies.

0.3.4 The External Degree

Bullough, Bullough & Soukup (1980, p. 239) recommend the New York Regents External Degree Programme (N.Y.R.E.D.P.) as a model programme. It offers both baccalaureate and associate diploma level nursing awards, and is focused entirely on assessment procedures. No classroom attendance is required and credits may be transferred from any accredited institution. Such an individualised and flexible programme could be a viable alternative to overcome the difficulties of attendance at a centralised institution for outpost nurses and those isolated from institutions by other responsibilities. Such centres have not proliferated, according to these authors, because of a

lack of clinical competency studies, which would facilitate programme planning (p. 239). Simms (in Duespohl, 1983, p. 104) comments that "external degree programs are a genuine mix of the formal and alternative systems - They seek to encompass the rigor and discipline of the traditional approach in the flexible space-time framework of the non traditional setting." The key to adaptation of external programmes to nursing education may be in retrieving one of nursing's older styles of training - to re-develop a corresponding system of preceptorship.

0.3.5 Preceptorship

Preceptorship, seconding nurse facilitators to function as teachers, observers, and evaluators was instigated at Capital School of Nursing in Washington, D.C. to minimise what Kramer (1974) calls reality shock - a common reaction of nurses to the disparity between expectations presented in the educational sphere and realities of the practice situation. (Chickerella & Lutz, in Duespohl, 1983, p. 126). These authors cite advantages of preceptorship as professional nurturance which not only reduces reality shock and the frustrations of new graduates, but provides opportunity for the preceptor to demonstrate competence and a sense

of responsibility; and a two-way learning exchange between student and preceptor. Adams (1980, p. 385) recognises a further advantage to the student in that he or she is provided with a role model who is also a practitioner. Disadvantages include the imposition of time on an already overworked preceptor who must maintain nursing duties, the difficulty of faculty evaluation, sorting out the source of educational inputs, and coordination of the schedules of student and preceptor. McFarlane (1984) suggests preceptoring as one method of achieving balance between the academic and practice spheres of nursing. Dobbie & Karlinsky (1982) describe a programme at the University of Calgary Faculty of Nursing, in which the combination of well planned preceptorship and self-directed clinical practicum has been highly rated by post R.N. students (p. 40).

An Australian example of the practicality of preceptoring is presented by Max Bone (1979, p. 89). He relates that the Adelaide T.A.F.E. successfully co-opted Adelaide Police Force specialists (an inspector and a detective from the department's educational services), to work full time on the college staff for one year to help work out suitable courses. Co-opting senior nurses to prepare suitable courses for either undergraduate or continuing education would

present an analogous situation. McArthur, Brooke & Bruni (1981, p. 38) concluded that the most frequently identified inadequacy of college graduates was in the technical and organisational areas of nursing skills, those which could conceivably be strengthened by a cooperative, professionally nurtured experience. This type of collaboration between nurse educators and experienced nursing personnel is proposed by several authors as the mechanism for consolidating goal achievement and improving services. (Adams, 1980; Ray & Flynn, 1980; White, Knockmueller & Yaksich, 1980). Collaborative teacher/learner ventures have been favourably received in recent years in many nursing programmes.

Based on Williams' (1977), premise that community health care is concerned with group health problems, a curriculum was designed at the University School of Nursing in Jerusalem in which the students, guided by experienced staff, take full responsibility for such group projects as anti-smoking and nutrition programmes. (Kurtzman, Black-Ben Ibgui, Pogrund & Monin, 1980, p. 737). A related endeavour takes place at the University of Arizona College of Nursing where community health nurses were previously seen to be merely transferring institutional-type care giving into the community setting. A professionally nurtured

learning experience which now sees the nurse preceding client assessment with a community assessment, has been attributed with fostering an interactive style of nurse/client problem solving. (Miller, 1982, p. 6). Archer & Fleshman (1981) 'share' their faculty positions at the University of California at San Francisco with graduate students, collaborating on projects, and have observed that their role modelling or mentoring style is adopted by the students who, in turn, serve as role models for their junior colleagues. As a result, a style of participative responsibility networking is nurtured, to the advantage of a community oriented nursing process.

The commonality of the above examples is a flexible, individualised, modular approach to curriculum development relevant to educational needs identified in the practice context. Through such innovation in practice and the trend towards research into the responsibilities, capabilities and educational preparation of the CHN, the clearly mandated goal of delivering community wellness care will be more accurately facilitated.

0.4 SUMMARY

In summary, nursing education in Australia is in a period of dynamic evolution. Political and educational leaders are in the process of evaluating options for changing the educational preparation od nurses toward optimal benefit to nurses, their client population, and society in general. Representatives of the profession, anxious to advance the status of the Australian nurse to closer proximity with his or her overseas counterparts and other health professionals, are encouraging that the 'training' be replaced with nurse 'education', relevant to role performance requirements. A need for precision in educational programmes is essential to guard against dissemination of current and future nurse, and nurse educator resources.

The literature suggests consensual views on education exist, including the needs for both specialist preparation, and continuing education for community health nursing . Alternatives in pre-service curricula are offered in the addition of specialty certification to various levels of generalist preparation. Consensus on the role of the CHN as primary care giver is also apparent in the studies.

Elaboration of component parts of that role identified the need for

multidisciplinary inputs, and a focus on problem-solving, teaching, research and organisational skills. Difficulties associated with accessibility to relevant educational inputs are evidently a common contextual constraint of the role. Measures to overcome these were suggested as development of external and individualised study components, and efficient presentation techniques, including preceptorship and the use of instructional technology.

As nursing is a practice discipline, research in the practice setting is necessary to identify current performance requirements and to relate this information to appropriate educational preparation strategies. With the focus on health care increasingly being placed on the community setting, it is to the nurse within that practice environment that this investigation addresses itself.

It remains to prescribe a curriculum specific to the identified needs of the Australian CHN which may, in its development, contribute to existing knowledge and future implementation of the practice of community health nursing.

CHAPTER THREE

METHODOLOGY

This chapter describes the design and procedures of the study under the following headings:

1. Overview of the Problem
2. Description of the Research Methodology
3. Research Design
4. Instrument Development
5. Selection of the Population Sample
6. Pilot Study
7. CHN Interviews Preceding the Survey
8. Collection of Data
9. Analysis of Data
10. Conclusions.

0.1 OVERVIEW OF THE PROBLEM

This study addresses the task performance requirements of the CHN. Six research questions derive from the objectives presented in chapter one:

1. What are the competencies which comprise the role of the CHN upon which a curriculum should be based?

2. What is the relationship between the community health nurses' education, experience and task performance?

3. What is the extent of decision-making in the daily activities of the CHN in Western Australia?

4. Do existing educational curricula adequately prepare for required practice performance in community health nursing?

5. Could the survey instrument be used to identify task performance requirements of other groups of nurses?

6. What recommendations arising from the data can be made regarding recruitment and educational programme

planning for community health nursing?

0.2 DESCRIPTION OF RESEARCH METHODOLOGY

The present study is an attempt to describe the extent of practice tasks of community health nurses, and therefore seeks to measure and evaluate what is being done rather than what is being achieved. As such, it is simultaneously qualitative and quantitative. It is anticipated that evaluation of task performance will ascertain the substantive adequacies and inadequacies of existing community health nursing curricula, allowing validation of existing programmes, or induction of relevant components for a new curricula. Insofar as the nature and extent of a specified set of data are required to describe which tasks are performed, by which nurses, and in what context, the survey format is selected as the means of data collection.

An attempt has been made to adhere to the guiding principles which underlie the survey format (Isaac & Michaël, 1981, p. 128). To ensure that the survey is systematic, appropriate in content coverage and efficient in data collection, consultation with nursing

researchers, administrators and practitioners has been engaged in. To ensure representativeness - reflecting the population of all possible tasks, the list was devised and evaluated for accuracy, adequacy and comprehensiveness. To ensure objectivity, the survey form was appraised by a panel of experts from a variety of nursing backgrounds. To ensure quantifiability, the method of data analysis has been developed in consultation with a data analyst and a programme for analysis developed.

A mailed self-administered questionnaire was selected as the most inexpensive, wide-ranging, simple, clear and anonymous form of survey. To secure a reasonable response rate, feasibility interviews were held with nursing supervisors, who surmised that community health nurses throughout the state would be amenable to a study which would address their needs and elevate their profile, on the condition that survey findings were related back to them. This guarantee was issued from the accompanying instructions. To assure that the questionnaire was understood and to provide content validity, seventeen follow-up interviews were conducted with a subset of participants, corroborating accurate categorisation of specific tasks. To assure that intended respondents replied to the questionnaires, they were addressed to individuals rather than to

regional offices. The survey questionnaire was field-tested to eliminate ambiguous items, to improve the format and to test the method of analysis.

0.3 RESEARCH DESIGN

A three part questionnaire was devised for the purpose of this survey. (see Appendix A). A letter of introduction and explanation included instructions for completing and returning the questionnaire. Part one was designed to elicit demographic information relating to qualifications, the nurse's functional category within community health nursing, and years of community-based nursing experience. In part two, participants were asked to identify tasks performed on each of the three dates designated for completion of this portion of the survey. The day's tasks were to be categorised according to ten descriptive categories. Within each descriptive category, tasks were to be identified and quantified according to origin, to yield the numbers of tasks which were respectively self, supervisor, client or other-initiated. Respondents were then asked to rate their perceived degree of preparation for performing tasks in each descriptive

category as either: 1. no expertise; 2. almost no expertise; 3. many problems; 4. one or a few problems; 5. no problem at all. Finally, the source or sources of preparation for tasks in each descriptive category was to be indicated as: basic nurse training, post-diploma course, in-service, supervisor, co-workers, books and/or articles, past experience, and explanation by client. Part three asked an open-ended, two part question addressing the nurse's needs: firstly regarding continuing education, and secondly, soliciting retrospective comment on her or his prior education relating to practice needs. A second question invited open comment to encourage non-categorised information pertinent to the study.

All parts of the questionnaire were designed so that responses could be coded for computer analysis, and all questionnaires were numbered to maintain accurate records of the response rate. Part two, to be completed on three dates on three consecutive weeks was numbered according to whether that survey portion was 1, 2, or 3 in each respondent's series. Dates were randomly selected by the researcher to provide a representative sample of each nurse's work days.

The survey was conducted as a field test on a sample of twelve community health nurses. Suggestions from the pilot study group resulted in editorial refinements

being made to the survey form to add clarity of presentation. The final survey form was mailed to 364 community health nurses throughout the state of Western Australia.

0.4 INSTRUMENT DEVELOPMENT

0.4.1 Preliminary Literature Review and Interviews

In order to devise and categorise a concise, yet comprehensive list of tasks typically performed by the Western Australian CHN, the literature on nursing, education and research methods was reviewed, and a series of interviews with community health nurses, nurse educators, and researchers undertaken.

The 'nursing process' categories of assessment, planning, implementation and evaluation were selected as recogniseable major categories into which all tasks required of the CHN could be classified. A list of specific tasks within the four categories was reiterated until it was considered to approximate those required of the CHN, then presented to a panel of

experts for evaluation. A request from the Commissioner of Public Health (Dr. J. McNulty), for permission to proceed with the investigation, yielded departmental authorization. (see Appendix B).

0.4.2 Task List Item Evaluation

The Panel

It was considered of critical importance that the task list panel could adequately anticipate the types of tasks required of both rural and urban community health nurses in the functional categories of field nurse, outpost nurse, child health nurse, and school health nurse. Accordingly, a panel of 13 was constructed, ten of whom had previously worked in at least one of these functional categories. Included were two community health nursing administrators, a Nurses Board education officer, a community health research officer, three nurse educators, five senior nurses for field, child health and school health, and one regional supervisor (see Appendix C). The purpose of the study was explained to panel members and the request made that each evaluate the accuracy, clarity and adequacy of list items and the overall utility of the list in enabling community health nurses to

identify his or her daily task performance requirements.

Item Selection

Members were asked to have the list, with comments, available to be picked up in one week. Personal retrieval of the lists was expected to encourage information and comment which panelists may have hesitated to submit in written form. Comments were categorised, and modifications made to the list accordingly, with a refined version presented back to the nine panel members who had prepared comment. The remaining four had chosen to collaborate in joint comment with other members. This procedure was repeated once, resulting in consensual agreement on item accuracy, clarity and adequacy, and a putative degree of usefulness of the resultant ten subcategories for task classification. Included in modifications to the original list was a re-categorisation of certain tasks and alterations of descriptive language. Those tasks judged to be incorrectly placed were replaced, those not included previously were added, and an attempt was made to improve the precision of information provided. The demographic questionnaire (Part One), and the open-ended questionnaire (Part Three), were then added to the task questionnaire (Part Two), and prepared in a survey format for a pilot

study.

The study was introduced to, and approved by a meeting of the Perth district community health nurse supervisors, and subsequently, telephone interviews of regional nurse supervisors for the Eastern Goldfields, Central, Pilbara and the Kimberley Regions elicited similar approval.

0.5 SELECTION OF THE POPULATION SAMPLE

The sample was drawn from the staff list of Community & Child Health Services and Regional Health Services, which was provided by Miss Joan Bedford, Research Officer, Health Department of Western Australia. From this list it was tabulated that 412 community health nurses currently practise in the Health Department. Of this number, 121 are field nurses, (98 rural, including 20 outpost nurses, and 23 urban); 123 are child health nurses, (77 rural, 46 urban); and 127 school health nurses, (44 rural and 83 urban). An additional forty-one nurses practise in the department's sub-specialty areas. These are as follows: One nurse for each of youth health, child development, the independent living centre, muscular dystrophy and

diabetes; two nurses for each of epidemiology, correspondence, Hansen's disease, hospital liaison and multiple sclerosis; three nurses for rheumatoid arthritis; four for children's daycare; five for school resources and seven for each of staff development and field nurses (flying). From the subspecialty areas it was decided to include the youth health and children's daycare among the numbers of child health nurses. Those from the remaining subspecialty areas would be excluded due to the uniqueness of their roles, which would render their responses beyond the scope of this study.

A total of 376 survey forms were mailed: 121 to community field nurses, 128 to child health nurses and 127 to school health nurses.

0.6 THE PILOT STUDY

Upon request, Health Department senior nurses and state advisers for community nursing, child health nursing, and school health nursing nominated a group consisting of nine metropolitan Perth community health nurses (three from each functional category of field, child health and school health nurse), and three

practising in rural areas, (one from each functional category), to pilot test the study.

One week prior to the pilot study, an announcement of the general study was placed in the Health Department community health nurses' newsletter, 'The Grapevine' (see Appendix D). A survey form was then mailed to each of the twelve nurses and included an introductory letter explaining the purpose of the study, and the fact that the recipient had been nominated as part of the pilot test group. A date, randomly selected from a two week span of each nurse's work days, was designated at the top of the task list form as the date for its completion. On the chance that the date selected was a non-working day for whatever reason, the nurse was instructed to complete the survey on the first working day following the date specified. Instructions on completing and returning the form were provided, and an invitation to discuss any part of the study was extended (see Appendix E).

0.7 CHN INTERVIEWS PRECEDING THE SURVEY

During the two week pilot study period, a visit was paid to the Eastern Goldfields region to conduct

in-depth interviews with the nurses in that region. The region includes representation of all functional categories of field, child health and school health nurses as well as outpost nurses, field nurses (flying), and Aboriginal health workers. It was anticipated that accompanying the nurses in their work environment would permit a greater understanding of the community health nurse's role in context. Coincidental reasons for selecting the region were practical and economic: an invitation to visit included transportation and accommodation.

0.8 COLLECTION OF DATA

Survey respondents were provided with Health Department envelopes stamped and addressed to Miss Joan Bedford, Statistics Branch. Her staff were instructed to separate all such envelopes from the usual mail, and arrangements were made for the questionnaires to be picked up by the researcher as they were received. As the questionnaire was designed to be completed over a three week period, six weeks was allowed between mailing the survey forms and follow-up reminder notices. Throughout the three week study period,

several clinics were visited to assist any nurses having difficulty completing the questionnaire. This was expedited by an invitation to accompany a metropolitan area supervisor on her clinic rounds. In addition, several visits were made in response to telephone enquiries.

An initially low response rate of 26 % (N=95), coupled with a relatively high number of telephone enquiries regarding the method of completing the survey, resulted in designing the follow-up reminder notice in such a way as to offer respondents a shorter, condensed version of the questionnaire as an alternative data gathering instrument. This survey form (questionnaire number two) was accompanied by a cover letter which shared the difficulties associated with the non-respondent in survey research, reinforced the purpose and impact of the study, and requested that the individual either return the original survey forms at the earliest convenience, or complete an abridged version of the survey (see Appendix F). This version requested the recipient to describe, in his or her own words, what was done on one typical work day within the following week. The demographic page and open ended comments section from questionnaire number one was attached, and the survey forms mailed to 269 non-responders and six identifiable individuals who

responded to questionnaire number one with incomplete information. A stamped envelope, addressed to the researcher, care of the Department of Education, University of Western Australia, was enclosed. Timed to coincide with the mailing of questionnaire number two, a reminder notice was placed in the Health Department community nurses newsletter, 'The Grapevine' (see Appendix G).

Upon receipt of the replies, tasks were coded according to the categories on the original task survey form. Coding difficulties became apparent from the inconsistency of descriptions of 'a typical day'. Many nurses described the typical day in terms of "I usually do..." followed by a description of the type, but not quantity of tasks. Other nurses described their day in terms of time allocated to each task. For example, "I spent four hours today conducting screening assessments." Some nurses designated both type and quantity of tasks, but without an accompanying classification list, often failed to include items such as planning, teaching, and documentation of activities. Therefore, the number of times a task was mentioned in each of these descriptions, was the number of tasks listed. It was anticipated that, although this coding procedure would not provide an accurate measure of tasks performed, analysis of the

distribut ion would further elaborate the types of tasks performed. That portion of the form which would have identified source of initiation, and degree and source of educational preparation for task performance, was left blank.

0.9 ANALYSIS OF DATA

Usable questionnaires were sorted from those returned. Seventeen questionnaires were returned as undeliverable due to the addressee being on leave, or having left the department. Unusable questionnaires were those with missing information and an unidentifiable author, or those which had been returned with a request to be excused from the survey. Usable questionnaires were coded and sent to the University computer department for analysis.

Statistical analysis was conducted to relate the nurses education and experience level, functional category, tasks performed, reported degree and source of preparation for task performance, identified needs for continuing education, and retrospectively identified needs for previous education.

To detect whether the selected variables of education and experience levels and functional category had any relationship to task distribution, source of initiation for tasks, degree and source of preparation of tasks performed, and identified educational needs, univariate and multivariate analysis was carried out.

0.10 CONCLUSIONS

It was expected that the method of combining interview and survey data would provide sufficient information to identify the competencies which comprise the role of the CHN. Details from the questionnaire survey would permit investigation of the relationship between participants' education, experience, and task performance, and provide an insight into the extent of decision-making apparent in the performance of tasks. This information would then provide the basis for an evaluation of the present community health nursing curriculum. In addition, future usefulness of the survey instrument, devised for this population of nurses in collaboration with a group of experienced professional nurses, could then be evaluated with a

view toward its applicability to other groups of participants. The final expectation was that the study would provide the basis for recommendations regarding performance related programme planning for community health nursing.

CHAPTER FOUR

FINDINGS

This chapter presents the following information:

1. Characteristics of the interview, pilot study and general study participants are described.

2. Preliminary analysis of the questionnaire is detailed.

3. Analysis and interpretation of data is used to answer the six research questions set out previously.

0.1 CHARACTERISTICS OF THE STUDY SAMPLE

0.1.1 The Goldfields Interview Participants

As mentioned in chapter three, interviews were held with nurses attached to the Goldfields region. The interviews were conducted during the course of daily activities, and were aimed at establishing three major features of the nurses' work situation; namely, representativeness of their present activites, the extent of wellness-oriented or typical community health nursing practice, and the nurses' perceived educational

needs for role performance.

A total of seventeen interviews were conducted, including those with seven field nurses, one child health nurse, three school health nurses, one field nurse (flying), three Aboriginal health workers, one nurse co-ordinator, and the regional nursing supervisor. These interviews were conducted while accompanying the nurses on the following activities: attending a weekly regional centre planning meeting; conducting an exercise group (Gentle Gym), for the well elderly; attending a one-day in-service seminar on music as a therapeutic aid in health care; assessing health needs at a migrant Aboriginal hostel, a country mission for Aboriginals, and a section of land at the town periphery known to be frequented by destitute Aboriginals; touring the community hospital with the health worker liaison officer; visiting an outpost nursing station for a day; conducting a VD screening clinic at the regional prison; attending health centres at two primary schools, a high school and a child health clinic; conducting a drop-in centre for mothers and their babies; attending a scheduled radio 'skid' for isolated nurses; organising the supply depot and planes for the Royal Flying Doctor Service between flights; arranging servicing for vehicles to travel to an outpost community.

0.1.2 The Pilot Study Participants

Eight of the twelve questionnaires mailed to the pilot survey group were returned completed (66.66%). Telephone solicitation failed to elicit response from the remaining four nurses. Respondents represented two field nurses from metropolitan Perth, one rural field nurse, three child health nurses and one school health nurse from metropolitan areas, and one school health nurse from a rural area. Distribution of educational levels included four R.N's with one post-basic certificate, one R.N. with two or more post-basic certificates, and three R.N.'s with two or more post-basic certificates and a nursing degree. The length of time participants had worked in community-based nursing ranged from one year to 20 years, the average being 6.75 years.

0.1.3 The General Survey Participants

The percentage of usable replies to the questionnaire was 26.44% (N =96). Participants included 18 field nurses (9 urban, 9 rural), two outpost nurses, forty-three child health nurses (31 urban, 12 rural),

and thirty-three school health nurses (22 urban, 11 rural). For purposes of analysis, the subcategories of high school, district school, and priorities school nurse were collapsed into the functional category 'school health nurse'.

Replies to the second questionnaire describing 'a typical day', numbered 48. Included were responses from thirteen field nurses (1 urban, 12 rural), two outpost nurses, thirteen child health nurses (9 urban, 4 rural), and twenty school health nurses (11 urban, 9 rural). Responses from that section of the questionnaire which identified continuing and previous education needs were combined with those of the respondents to the first questionnaire for analysis. The following section outlines the preliminary analysis of the questionnaire data.

0.2 ANALYSIS OF THE QUESTIONNAIRE

0.2.0.1 Response Rate

Responses analysed represent a proportion of 363 potential respondents. Removed from the original figure of 367 mailed, are the twelve pilot study nurses, and one rural field nurse, found to be a duplicate. The overall reply rate to both questionnaires was 52.61% (N=191). This included 26.17% (N=95) who replied to the mailing of questionnaire number one, 4.68% (N=17) who returned questionnaire number one following receipt of the second questionnaire, and an additional 21.76% (N=79) who responded to the second questionnaire.

0.2.0.2 Characteristics of Respondents

Frequency of usable responses to the questionnaire are presented in Table 1 according to functional, education, and experience categories. Table 2 illustrates the distribution of post-basic certificates across functional categories.

TABLE 1

FREQUENCY OF RESPONSES FROM FIELD, OUTPOST, CHILD HEALTH AND SCHOOL HEALTH NURSES (N=96)

FUNCTIONAL CATEGORY	EDUCATION CATEGORY					EXPERIENCE CATEGORY				
	1 R.N. Only	2 R.N. + Other	3 R.N. + 1 cert.	4 R.N. + 2 cert.	5 R.N. + degree	1 > 2 yrs	2 2-5	3 6-10	4 11-20	5 21 +
FIELD	10	3	0	4	1	0	4	7	5	2
OUTPOST	1	0	0	0	1	1	0	0	1	0
CHILD HEALTH	29	0	2	11	1	4	14	10	14	1
SCHOOL HEALTH	19	9	2	3	0	5	6	19	2	1
ALL URBAN	41	5	4	11	1	5	14	24	17	2
ALL RURAL	18	7	0	7	2	5	10	12	5	2
ALL NURSES	59	12	4	18	3	10	24	36	22	4

TABLE 2

FREQUENCY DISTRIBUTION OF REGISTRABLE POST-BASIC CERTIFICATES OF RESPONDENTS (N=96)

FUNCTIONAL CATEGORY	POST BASIC CERTIFICATES			
	COMMUNITY/ PUBLIC HEALTH/ HEALTH VISITOR	CHILD HEALTH	MIDWIFERY	OTHER
FIELD	2	6	10	3
OUTPOST	0	2	2	0
CHILD HEALTH	3	36	40	6
SCHOOL HEALTH	3	5	11	1
ALL URBAN	4	32	43	4
ALL RURAL	4	17	20	6
ALL NURSES	8	49	63	10

Responses by functional category ranged from 31 in child health (urban), to two outpost nurses, as illustrated in Table 1. Educational preparation of participants ranged from 59 in the R.N. only (group 1), education group, to 3 in the degree level (group 5) education group. As illustrated in Table 2, midwifery certificates were held by 63 nurses (65.63% of this population), child health certificates by 49 nurses (51.04%), community health, public health or health visitor certificates by 8 nurses (8.33 %), and other registrable certificates by 10 nurses (10.42% of all respondents). The length of time respondents had worked in community-based nursing ranged from several months to 31 years, the average being 8.33 years. Additional educational programmes attended by respondents are listed in Appendix H.

0.2.0.3 Data Analysis

Preliminary analysis of the questionnaire revealed that the average number of daily tasks performed by all nurses was 245.71. These were distributed over the ten task categories as illustrated in Table 3. Analysis of variance figures show no significant differences in the total number of tasks performed according to education, experience or functional categories of nurses (Table 4).

Table 3.

Frequency of Occurrence of Individual Tasks Relative to Total Daily Tasks: Rank Ordered. (N = 96)

TASK	AVERAGE NUMBER*	PERCENT OF TOTAL
Documentation	55.95	22.77
History Taking	44.21	17.99
Teaching	28.34	11.53
Direct Care Giving	21.70	8.83
Deciding Priorities	19.24	7.83
Counselling	17.44	7.10
Resources Identification	17.04	6.94
Follow-up & Review	15.80	6.43
Outcome Evaluation	15.33	6.24
Coordination & Liaison	10.67	4.34
All Tasks	245.71	100.00

* Figures represent the average of responses on three survey days.

Table 4.

Analysis of Variance for Functional, Education, And Experience Groups for Total Tasks Performed (N = 96).

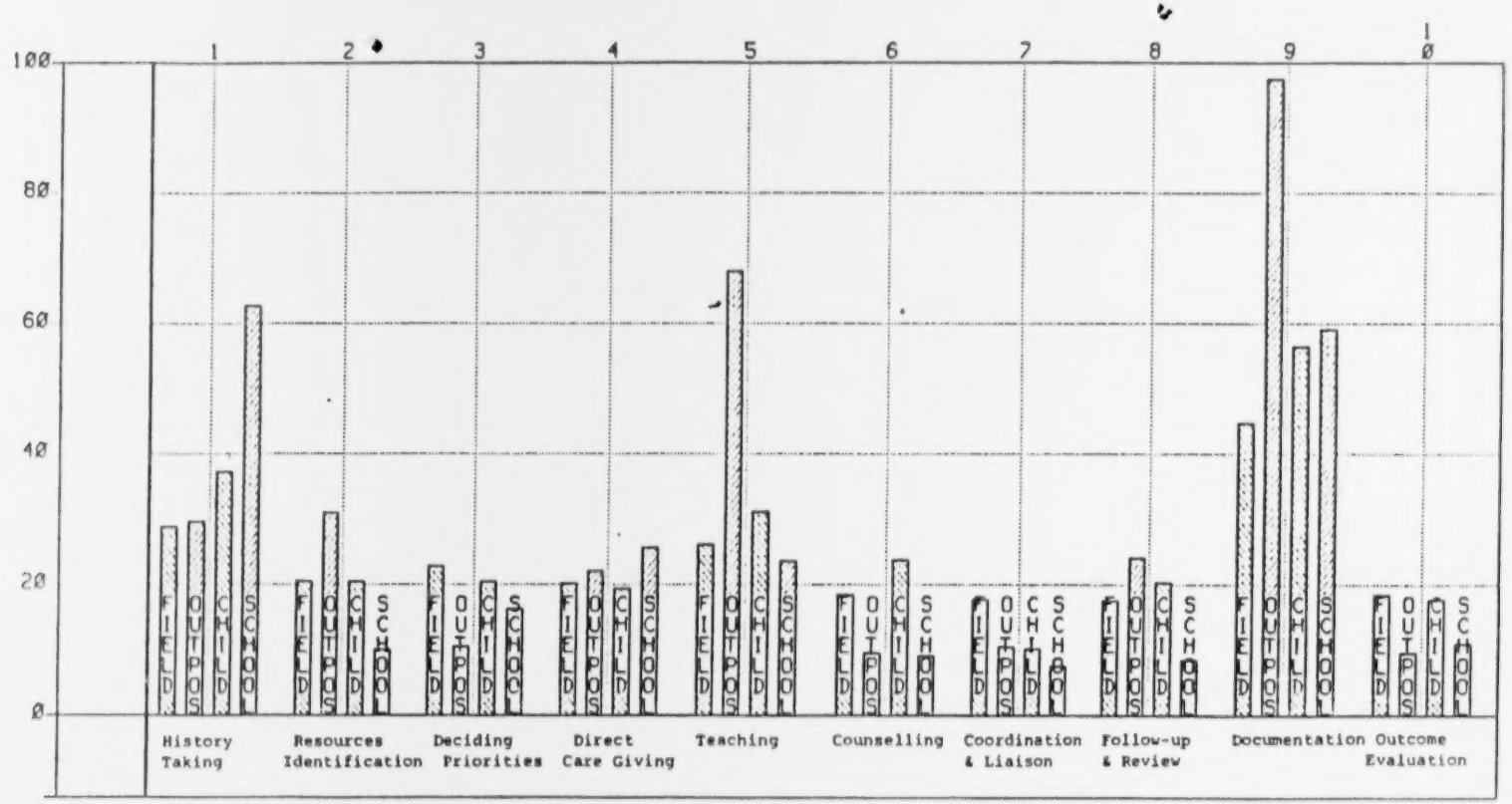
	FUNCTIONAL GROUPS	URBAN/RURAL	EDUCATION GROUPS	EXPERIENCE GROUPS
	Average #	Average #	Average #	Average #
df	3	1	4	4
p>.05	.9101	.8492	.4608	.7826

0.2.0.4 Individual Tasks

Figure 4 shows the comparison of individual tasks reported by functional groups of nurses.

Figure 4.

A Comparison of Individual Tasks Performed by Field, Outpost, Child Health and School Health Nurses.



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Frequency distribution of individual tasks can be seen according to functional, education, and experience categories in Appendices I., J., and K. respectively. Analysis of variance for individual tasks across functional, education, and experience categories shows several significant differences, as can be seen in Tables 5 - 14. Comparison of urban/rural nurses, demonstrates that rural nurses report a lower number (sig. = .0209; 1 df), and percentage (sig. = .0006; 1 df) of documentation tasks (Table 13), and a higher percentage of deciding priorities tasks (sig. = .0245; 1 df, Table 7). Field nurses report a higher percentage (sig. = .0457; 3 df) of coordination and liaison tasks (Table 11). School health nurses report a higher number (sig. = .0017; 3 df), and percentage (sig. = .0001; 3 df) of history taking (Table 5), a higher percentage of direct care giving (sig. = .0304; 3 df), and a lower percentage of follow-up and review activities (sig. = .0038; 3 df - Tables 8 and 12). No significant differences were found for individual tasks across experience categories. The sole significant difference across education categories was found for outcome evaluation tasks.

TABLE 5

ANALYSIS OF VARIANCE OF FUNCTIONAL, EDUCATION, AND EXPERIENCE GROUPS FOR HISTORY TAKING TASKS (N=96)

	FUNCTIONAL GROUPS		URBAN/RURAL		EDUCATION GROUPS		EXPERIENCE GROUPS	
	Ave.	%	Ave.	%	Ave.	%	Ave.	%
df	3	3	1	1	4	4	4	4
$p < .05$	.0017*	.0001*	.7707	.8293	.1234	.1375	.2249	.3573

* Significant at the .05 level.
Average figures represent a comparison of the average number of times each type of task is performed by each group.

Percentage figures represent a comparison of the percentage of times each type of task is performed by each group relative to all tasks.

TABLE 6

ANALYSIS OF VARIANCE OF FUNCTIONAL, EDUCATION, AND EXPERIENCE GROUPS FOR RESOURCES IDENTIFICATION TASKS (N=96)

	FUNCTIONAL GROUPS		URBAN/RURAL		EDUCATION GROUPS		EXPERIENCE GROUPS	
	Ave.	%	Ave.	%	Ave.	%	Ave.	%
df	3	3	1	1	4	4	4	4
$p < .05$	.1372	.0889	.3024	.4897	.6484	.7354	.6365	.3681

TABLE 7

ANALYSIS OF VARIANCE OF FUNCTIONAL, EDUCATION, AND EXPERIENCE GROUPS FOR DECIDING PRIORITIES TASKS (N=96)

	FUNCTIONAL GROUPS		URBAN/RURAL		EDUCATION GROUPS		EXPERIENCE GROUPS	
	Ave.	%	Ave.	%	Ave.	%	Ave.	%
df	3	3	1	1	4	4	4	4
$p < .05$	.7621	.1993	.2333	.0245*	.4950	.7106	.7668	.3956

* Significant at the .05 level

TABLE 8

ANALYSIS OF VARIANCE OF FUNCTIONAL, EDUCATION, AND EXPERIENCE GROUPS FOR DIRECT CARE GIVING TASKS (N=96)

	FUNCTIONAL GROUPS		URBAN/RURAL		EDUCATION GROUPS		EXPERIENCE GROUPS	
	Ave.	%	Ave.	%	Ave.	%	Ave.	%
df	3	3	1	1	4	4	4	4
$p < .05$	.7232	.0304*	.6151	.8865	.4455	.5191	.5966	.1103

* Significant at the .05 level

TABLE 9

ANALYSIS OF VARIANCE OF FUNCTIONAL, EDUCATION, AND EXPERIENCE GROUPS FOR TEACHING TASKS (N=96)

	FUNCTIONAL GROUPS		URBAN/RURAL		EDUCATION GROUPS		EXPERIENCE GROUPS	
	Ave.	%	Ave.	%	Ave.	%	Ave.	%
df	3	3	1	1	4	4	4	4
$p < .05$	.1590	.1961	.4549	.1395	.4239	.9253	.5141	.7692

TABLE 10

ANALYSIS OF VARIANCE OF FUNCTIONAL, EDUCATION, AND EXPERIENCE GROUPS FOR COUNSELLING TASKS (N=96)

	FUNCTIONAL GROUPS		URBAN/RURAL		EDUCATION GROUPS		EXPERIENCE GROUPS	
	Ave.	%	Ave.	%	Ave.	%	Ave.	%
df	3	3	1	1	4	4	4	4
$p < .05$	.0510*	.0062*	.6167	.9501	.7142	.5231	.2014	.1159

* Significant at the .05 level

TABLE 11

ANALYSIS OF VARIANCE OF FUNCTIONAL, EDUCATION, AND EXPERIENCE GROUPS FOR COORDINATION AND LIAISON TASKS (N=96)

	FUNCTIONAL GROUPS		URBAN/RURAL		EDUCATION GROUPS		EXPERIENCE GROUPS	
	Ave.	%	Ave.	%	Ave.	%	Ave.	%
df	3	3	1	1	4	4	4	4
$p < .05$	.2408	.0457*	.1656	.0568	.2440	.0800	.9381	.9251

* Significant at the .05 level

TABLE 12

ANALYSIS OF VARIANCE OF FUNCTIONAL, EDUCATION, AND EXPERIENCE GROUPS FOR FOLLOW-UP AND REVIEW TASKS (N=96)

	FUNCTIONAL GROUPS		URBAN/RURAL		EDUCATION GROUPS		EXPERIENCE GROUPS	
	Ave.	%	Ave.	%	Ave.	%	Ave.	%
df	3	3	1	1	4	4	4	4
$p < .05$	.0800	.0038*	.6980	.6720	.4105	.0644	.7989	.8600

* Significant at the .05 level

TABLE 13

ANALYSIS OF VARIANCE OF FUNCTIONAL, EDUCATION, AND EXPERIENCE GROUPS FOR DOCUMENTATION TASKS (N=96)

	FUNCTIONAL GROUPS		URBAN/RURAL		EDUCATION GROUPS		EXPERIENCE GROUPS	
	Ave.	%	Ave.	%	Ave.	%	Ave.	%
df	3	3	1	1	4	4	4	4
$p < .05$	.5943	.7860	.0209*	.0006	.1396	.3729	.7294	.9890

* Significant at the .05 level

TABLE 14

ANALYSIS OF VARIANCE OF FUNCTIONAL, EDUCATION, AND EXPERIENCE GROUPS FOR OUTCOME EVALUATION TASKS (N=96)

	FUNCTIONAL GROUPS		URBAN/RURAL		EDUCATION GROUPS		EXPERIENCE GROUPS	
	Ave.	%	Ave.	%	Ave.	%	Ave.	%
df	3	3	1	1	4	4	4	4
$p < .05$	.6756	.0721	.3393	.1847	.2961	.0492*	.6986	.5710

* Significant at the .05 level

0.2.1 Source of Initiation

Source of initiation for task performance was reported as predominantly self-initiated (83.00% of all sources identified). Table 15 shows the distribution of sources for self, client, supervisor and other-initiated tasks. Appendices L., M., and N. detail source of initiation for functional, education, and experience groups. As can be seen in Table 16 - 19, analysis of variance reveals no significant differences for source of initiation across education or experience groups. Differences across functional categories include a higher percentage of reported self-initiated tasks for urban nurses (sig. = .0255; 1 df - Table 16), a higher number (sig. = .0213; 1 df), and percentage (sig. = .0402; 1 df) of supervisor-initiated tasks for rural nurses (sig. = .0402, F = 4.3293 - Table 17); and a higher percentage (sig. = .0259; 3 df) of other-initiated tasks for field nurses (Table 19).

Table 15.

Frequency Distribution of Self, Supervisor, Client and Other-Initiated Tasks: Rank Ordered (N = 96).

SOURCE OF INITIATION	AVERAGE # *	PERCENTAGE
Self	203.93	83.00
Client	27.13	11.04
Other	10.05	4.09
Supervisor	4.59	1.87
All Sources	245.71	100.00

* Figures represent the average of responses on three survey days.

TABLE 16

ANALYSIS OF VARIANCE OF FUNCTIONAL, EDUCATION, AND EXPERIENCE GROUPS FOR SELF-INITIATED TASKS (N=96)

	FUNCTIONAL GROUPS		URBAN/RURAL		EDUCATION GROUPS		EXPERIENCE GROUPS	
	Ave.	%	Ave.	%	Ave.	%	Ave.	%
df	3	3	1	1	4	4	4	4
$p < .05$	.5150	.2485	.7162	.0255*	.6734	.9254	.6833	.6357

* Significant at the .05 level

TABLE 17

ANALYSIS OF VARIANCE OF FUNCTIONAL, EDUCATION, AND EXPERIENCE GROUPS FOR SUPERVISOR-INITIATED TASKS (N=96)

	FUNCTIONAL GROUPS		URBAN/RURAL		EDUCATION GROUPS		EXPERIENCE GROUPS	
	Ave.	%	Ave.	%	Ave.	%	Ave.	%
df	3	3	1	1	4	4	4	4
$p < .05$	.1082	.1575	.0213*	.0402*	.3159	.6255	.3713	.4277

* Significant at the .05 level

TABLE 18

ANALYSIS OF VARIANCE OF FUNCTIONAL, EDUCATION, AND EXPERIENCE GROUPS FOR CLIENT-INITIATED TASKS (N=96)

	FUNCTIONAL GROUPS		URBAN/RURAL		EDUCATION GROUPS		EXPERIENCE GROUPS	
	Ave.	%	Ave.	%	Ave.	%	Ave.	%
df	3	3	1	1	4	4	4	4
$p < .05$	.4217	.6484	.5721	.1286	.2924	.3354	.9036	.7664

TABLE 19

ANALYSIS OF VARIANCE OF FUNCTIONAL, EDUCATION, AND EXPERIENCE GROUPS FOR OTHER-INITIATED TASKS (N=96)

	FUNCTIONAL GROUPS		URBAN/RURAL		EDUCATION GROUPS		EXPERIENCE GROUPS	
	Ave.	%	Ave.	%	Ave.	%	Ave.	%
df	3	3	1	1	4	4	4	4
$p < .05$	.1706	.0259*	.2393	.2469	.9699	.8349	.8304	.1289

* Significant at the .05 level

0.2.1.1 Source of Preparation

Rank order of identified sources of preparation for task performance can be seen in Table 20. Sources of preparation according to functional, education, and experience categories can be seen in Appendices O., P., and Q. Analysis of variance of sources of preparation (Tables 21 - 28) identified by education groups revealed that nurses from the two highest education categories (groups 4 and 5) identified post-diploma course (sig = .0001; 4 df); experience (sig. = .0410; 4 df); and books and articles (sig. = .0141; 4 df), with greater frequency than the lower education categories (groups 1, 2, and 3). No significant differences were found between sources of preparation identified and experience group.

When sources of preparation were analysed according to functional categories, rural nurses identified basic training (sig. = .0269, 1 df); books and articles (sig. = .0013 1 df); and client explanation (sig. = .0269; 1 df), a greater number of times than urban nurses. Child health nurses identified post-diploma course (sig. = .0057; 3 df); and inservice (sig. = .0163 3 df), more frequently than other nurses. Books and

articles were identified proportionately fewer times by school health nurses and a greater number of times by the two outpost nurses (sig. = .0013; 3 df).

Table 20.

Frequency of Occurrence of Source of Preparation Items. (N = 96).

SOURCE OF PREPARATION	Average # *	Percent of Total
Experience	18.13	21.27
Inservice	15.01	17.61
Basic Training	13.91	16.32
Books, Articles	10.47	12.28
Client Explanation	9.32	10.93
Post-Diploma Course	8.41	9.87
Co-Workers	6.96	8.17
Supervisor	3.08	3.61
All Sources	85.24	100.00

* Figures represent the average of all sources identified on three survey days.

TABLE 21

ANALYSIS OF VARIANCE OF FUNCTIONAL, EDUCATION, AND EXPERIENCE GROUPS FOR SOURCE OF PREPARATION : BASIC TRAINING (N=96)

	FUNCTIONAL GROUPS		URBAN/RURAL		EDUCATION GROUPS		EXPERIENCE GROUPS	
	Ave.	%	Ave.	%	Ave.	%	Ave.	%
df	3	3	1	1	4	4	4	4
$p < .05$	.7623		.0269*		.0864		.7393	

* Significant at the .05 level

TABLE 22

ANALYSIS OF VARIANCE OF FUNCTIONAL, EDUCATION, AND EXPERIENCE GROUPS FOR SOURCE OF PREPARATION : POST-DIPLOMA COURSE (N=96)

	FUNCTIONAL GROUPS		URBAN/RURAL		EDUCATION GROUPS		EXPERIENCE GROUPS	
	Ave.	%	Ave.	%	Ave.	%	Ave.	%
df	3	3	1	1	4	4	4	4
$p < .05$	.0057*		.7983		.0001*		.2397	

* Significant at the .05 level

TABLE 23

ANALYSIS OF VARIANCE OF FUNCTIONAL, EDUCATION, AND EXPERIENCE GROUPS FOR SOURCE OF PREPARATION : INSERVICE (N=96)

	FUNCTIONAL GROUPS		URBAN/RURAL		EDUCATION GROUPS		EXPERIENCE GROUPS	
	Ave.	%	Ave.	%	Ave.	%	Ave.	%
df	3	3	1	1	4	4	4	4
$p < .05$	.0163*		.3945		.1618		.0666	

* Significant at the .05 level

TABLE 24

ANALYSIS OF VARIANCE OF FUNCTIONAL, EDUCATION, AND EXPERIENCE GROUPS FOR SOURCE OF PREPARATION : SUPERVISOR (N=96)

	FUNCTIONAL GROUPS		URBAN/RURAL		EDUCATION GROUPS		EXPERIENCE GROUPS	
	Ave.	%	Ave.	%	Ave.	%	Ave.	%
df	3	3	1	1	4	4	4	4
$p < .05$	.2060		.6545		.9313		.6504	

TABLE 25

ANALYSIS OF VARIANCE OF FUNCTIONAL, EDUCATION, AND EXPERIENCE GROUPS FOR SOURCE OF PREPARATION : CO-WORKERS (N=96)

	FUNCTIONAL GROUPS		URBAN/RURAL		EDUCATION GROUPS		EXPERIENCE GROUPS	
	Ave.	%	Ave.	%	Ave.	%	Ave.	%
df	3	3	1	1	4	4	4	4
$p < .05$	.1987		.1774		.4743		.7839	

TABLE 26

ANALYSIS OF VARIANCE OF FUNCTIONAL, EDUCATION, AND EXPERIENCE GROUPS FOR SOURCE OF PREPARATION : BOOKS, ARTICLES (N=96)

	FUNCTIONAL GROUPS		URBAN/RURAL		EDUCATION GROUPS		EXPERIENCE GROUPS	
	Ave.	%	Ave.	%	Ave.	%	Ave.	%
df	3	3	1	1	4	4	4	4
$p < .05$	.0013*		.0020*		.0141*		.1151	

* Significant at the .05 level

TABLE 27

ANALYSIS OF VARIANCE OF FUNCTIONAL, EDUCATION, AND EXPERIENCE GROUPS FOR SOURCE OF PREPARATION : EXPERIENCE (N=96)

	FUNCTIONAL GROUPS		URBAN/RURAL		EDUCATION GROUPS		EXPERIENCE GROUPS	
	Ave.	%	Ave.	%	Ave.	%	Ave.	%
df	3	3	1	1	4	4	4	4
$p < .05$	.1773		.0763		.0410*		.4275	

* Significant at the .05 level

TABLE 28

ANALYSIS OF VARIANCE OF FUNCTIONAL, EDUCATION, AND EXPERIENCE GROUPS FOR SOURCE OF PREPARATION : CLIENT EXPLANATION (N=96)

	FUNCTIONAL GROUPS		URBAN/RURAL		EDUCATION GROUPS		EXPERIENCE GROUPS	
	Ave.	%	Ave.	%	Ave.	%	Ave.	%
df	3	3	1	1	4	4	4	4
$p < .05$	.0176*		.0219*		.0665		.3787	

* Significant at the .05 level

0.2.1.2 Degree of Preparation

Table 29 sets out the frequency distribution for degree of preparation items. Of the 1944 ratings received from respondents, the majority (92.75%) provided ratings of none or a few problems. Nearly half (49.18%) rated degree of preparation as 'no problems'; 43.57% rated it as 'few problems'; 4.71% provided a rating of 'many problems'; 1.08% rated it as 'almost no expertise'; and .72% submitted ratings of 'no expertise'. Appendices R., S., and T. illustrate the degree of preparation ratings according to functional, education, and experience categories, respectively, and Appendix U. shows the frequency of degree of preparation ratings for individual tasks. Analysis of variance was not conducted for degree of preparation items due to the high concentration of ratings in the two highest categories (none or a few problems).

Table 29.

Frequency Distribution of Degree of Preparation Items Rank Ordered (N = 96).

DEGREE OF PREPARATION	AVERAGE # *	PERCENT OF RATINGS
No Problems	956	49.18
Few Problems	847	43.57
Many Problems	106	5.45
Almost No Expertise	21	1.08
No Expertise	14	.72
All Ratings	1944	100.00

* Figures represent the average of responses on three survey days.

0.2.1.3 Educational Needs

Respondents to both questionnaires were combined for analysis of educational needs. Tables 30 and 31 illustrate the distribution of respondents in each education and experience group. Tables 32 and 33 delineate those ten needs for continuing education and previous education which were identified most frequently by the total population. Other needs which were identified singly within functional, education or experience categories appear in each list as miscellaneous items.

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TABLE 30

FREQUENCY OF IDENTIFICATION OF CONTINUING EDUCATION NEEDS BY NURSES IN FUNCTIONAL, EDUCATIONAL AND EXPERIENCE CATEGORIES (RESPONSES = 193)

FUNCTIONAL CATEGORY						EDUCATION CATEGORY					EXPERIENCE CATEGORY				
Field	Outpost	Child Health	School Health	All Urban	All Rural	R.N. Only	R.N. + Other	R.N. + 1 cert.	R.N. + 2 cert.	R.N. + 2 cert. + degree	> 2 yrs	2-5 yrs	6-10 yrs	11-20 yrs	21 +
						(1)	(2)	(3)	(4)	(5)	(1)	(2)	(3)	(4)	(5)
51	4	50	88	104	89	120	26	21	20	6	23	47	74	37	12

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TABLE 31

FREQUENCY OF IDENTIFICATION OF PREVIOUS EDUCATION NEEDS BY NURSES IN FUNCTIONAL, EDUCATIONAL AND EXPERIENCE CATEGORIES (RESPONSES = 188)

FUNCTIONAL CATEGORY						EDUCATION CATEGORY					EXPERIENCE CATEGORY				
Field	Outpost	Child Health	School Health	All Urban	All Rural	R.N. Only	R.N. + Other	R.N. + 1 cert.	R.N. + 2 cert.	R.N. + 2 cert. + degree	> 2 yrs	2-5 yrs	6-10 yrs	11-20 yrs	21 +
						(1)	(2)	(3)	(4)	(5)	(1)	(2)	(3)	(4)	(5)
56	5	57	70	117	71	112	26	11	28	11	23	44	60	49	12

Table 32.

Frequency of Occurrence of Continuing Education Needs as Identified by All Respondents. Rank Ordered (N = 144).

NEED	NUMBER	PERCENT *
General Increase in Continuing Education	15	7.77
Counselling & Human Relations Skills	44	22.80
Current Medical Conditions	37	19.17
Coping/Stress Management	12	6.22
Practise in Community & Clinical Nursing	11	5.70
Teaching Techniques	9	4.66
Information Sharing with Other Nurses	9	4.66
Community Liaison Skills	8	4.15
Time off to Attend Courses	8	4.15
Role Related Topics	7	3.63
Nursing Studies - Theory	6	3.11
Miscellaneous and Single Items	27	13.99
Total Needs Identified	193	100.00

* Number refers to the number of times a need is identified. Percent refers to the percent of all needs identified.

Table 33.

Frequency of Occurrence of Previous Education Needs as Identified by All Respondents. Rank Ordered (N = 144).

NEED	NUMBER	PERCENT *
General Increase in Previous Education	11	5.85
Counselling & Human Relations Skills	55	29.26
Practise in Community & Clinical Nursing	26	13.83
Current Medical Conditions	12	6.38
Nursing Studies - Theory	11	5.85
Role Related Topics	10	5.32
Community Liaison Skills	9	4.79
Coping/Stress Management	9	4.79
Time off to Attend Courses	6	3.19
Teaching Techniques	4	2.13
Tertiary Level Education	4	2.13
Miscellaneous and Single Items	31	16.49
All Needs	188	100.00

* Number refers to the number of times a need is identified.

0.2.1.4 Continuing Education

Responses to continuing education needs numbered 193, with the greatest number coming from school health nurses (45.6% of all functional groups), those in the R.N. only education group,(62.18% of all education groups), and those with 6 - 10 years of community-based experience (38.86% of all experience groups - see Table 30). The two most frequently occurring needs from all groups were reported as the need for counselling and related human relations skills, and the need for continuing updates on current medical conditions (Table 32).

Of the total respondents, 10.42% (N = 15), stated that they would like to see an increase in inservice education. Sixteen respondents (11.11%), stated that they were happy with the present inservice provisions.

0.2.1.5 Previous Education Needs

Responses to the question of what would have enhanced previous education numbered 188. As with identified continuing education needs, the highest rate of

response was from school health nurses (37.23% of all functional groups), those with 6 - 10 years' experience (31.91% of all experience groups), and those in the R.N. only education category (59.57% of all education groups - Table 31). The two most frequently identified needs for previous education, as can be seen in Table 33, were counselling and related skills, and practise in community and clinical nursing.

Eleven respondents (7.64%) stated that they would have preferred an increase in basic training. This compares to 4.17% (N = 6) who commented that they were satisfied with basic training.

0.2.1.6 Open Ended Comments

Open ended comments received numbered 236. The majority (35.6%) addressed educational needs for community health nursing. Of these, 18.64% were comments on continuing education, 8.9% discussed educational preparation, 4.24% addressed the issue of access to nursing education, and 3.81% related to the educational orientation given by the Health Department. Thirteen comments elaborated the importance of experience in community health nursing. The role of the community health nurse was described in 109

comments. Of these, 9.75% were general comments providing insight into the nature of nursing in the community; 16.95% provided specific information on the duties of the school health nurse; 5.08% were comments on working conditions; 5.93% addressed the burden of documentation tasks; 2.12% described the stress of job requirements; and 1.69% explained the human relations skills required of the nurse. A further 11 comments addressed miscellaneous topics ranging from reiterating continuing education needs, to a plea for resource materials for teaching health workers. Thirty comments (12.71%) related to the questionnaire survey, and with two exceptions, which declared the usefulness as outweighing the burden of the study, these addressed the difficulties associated with completing such a survey in addition to a busy work day.

Data from the questionnaire will be related to the research questions which follow.

0.3 ANALYSIS OF THE RESEARCH QUESTIONS

The purpose of the major analysis in this study is to investigate the competencies which comprise the role of the CHN, and the subsequent implications for development of a curriculum to prepare nurses for this role. The research questions presented in chapter three will be used to guide the analysis. Each of these questions is treated separately in the following analysis.

0.3.1 Question One:

What are the competencies which comprise the role of the CHN upon which a curriculum should be based?

Information from both the questionnaire data and the interviews conducted address this first research question.

0.3.1.1 Interview Data

During the interviews three questions were asked of each nurse:

1. Is this a typical day for you?

2. What percentage of your usual work week is spent in wellness-oriented nursing, as compared to illness-related care-giving?

3. What educational needs do you have for your present role?

Information from these interviews elaborate the role of the CHN, and will be detailed under this research question as addressing the competencies which comprise the role of the CHN.

0.3.1.2 The Typical Day

The major determinants of tasks performed on a usual day were contextual. When asked what comprised the usual day, field, child health and school health nurses responded that the typical day depended upon community needs and the availability of her time and resources, rather than on her particular credentials. [1]

Assessing short-term community needs was done by all nurses, often in collaboration with co-workers, and reviewed almost daily. Continuing communication between staff facilitated group assessments. The 'community' was represented by a mothers' group for some, a hostel for others, a family, or class of school children for others. Weekly planning meetings provided a forum for the nurses, their supervisor and co-ordinator, and the four Aboriginal health workers attached to regional headquarters, to decide the following week's tasks, and priorise longer-term planning. The meeting which I attended eventuated in a community nurse offering to take on partial responsibility for a child health function, another

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1. The population of nurses in this series of interviews was exclusively female, hence the use of the feminine gender in description.

offering to substitute in a specialty (Arthritis) clinic, while the regular clinic nurse was on leave, and several negotiated, collaborative ventures being planned based on community need and availability of staff. This appeared to be the usual strategy. The co-ordinator's role was very much in evidence at this meeting. Her primary function seemed to require constant awareness of all activities, and the location of all staff members. She maintains a constant list updating the status of clients each nurse is dealing with, in order to receive and answer queries coming in on her three times daily radio skids with the nurses in the outposts. She also maintains information on those who are travelling away from regional headquarters on any given day, and is the contact person for anyone who may be dealing with clients from the region, such as physicians, social workers or hospital staff.

The meeting was overseen by the supervisor who, while allowing task allocation to be decided by the group, injected her assessment of regional needs. This dimension served to maintain the broad objective of providing for the needs of as many groups within the region as possible, yet did not detract from maintaining as relatively high priority, those programmes which certain individuals had fostered through special interest and expertise. An example was

the 'Gentle Gym' programme, which two nurses have successfully instigated and maintained for the well elderly. For programme consistency and continuity and to maintain the established relationships, the group carefully and cooperatively allocates planning and programme time to the two nurses involved.

This group of nurses displayed a sense of independence in decision-making regarding task allocation, while priorities for meeting community needs appeared to be undisputed. Once major needs were covered, each nurse was then free to decide how and when to meet the needs falling into her specific area of responsibility. For example, the clinics conducted at the prison, the Aboriginal hostel, the mission, the schools and the child health centres were parceled out to those nurses with both interest and expertise. Each nurse had an input regarding which areas of responsibility and to what extent she would be involved. The child health and school health nurses' roles were predetermined by their having selected those respective functional categories when accepting employment with the region, but for the field nurse, any number of projects or responsibilities could present themselves once she had attached herself to the region.

Each nurse was allowed the freedom to devise her own

plans for implementing the tasks required of her. The school health nurses set out a plan for assessing children in a specified number of schools for each school year (with the exception of the high school nurse, who is attached to only one school). They then organise time and resources around the plan for the school year and the expectation of unforeseen needs which arise from screening and assessments. These include such things as home visits or follow-up activities on children with previously identified problems. Likewise, the child health nurse conducts her weekly activities according to the scheduled clinics and her weekly 'Child Health of the Air' programme, in which she dialogues with parents throughout the region through the radio network of the Royal Flying Doctor Service (R.F.D.S.). She is then left to conduct the remainder of her responsibilities as she sees fit, making home visits, responding to individual needs, and running such groups as a mother's self-help group.

This style of practice is what most community health nurses described as the essence of the role of the CHN. The responsibility and autonomy which the job offers gives them a sense of striving and self-esteem, providing job satisfaction surpassing that of the relatively restricted institutionally-based nurse.

Adoption by a client of nursing recommendations leading to an improvement in health, prevention of illness or deterioration of a condition, is described as sustaining on the busiest of days. That same measure of helpfulness may be offered by the hospital nurse, however, unlike her counterpart in the community, she is seldom there to witness client progress, or follow a newborn or school child through the developmental stages. Several of the nurses interviewed had spent in excess of ten years in responsible hospital positions, and all reiterated the attractive feature of community health nursing as the autonomy afforded in the practice context.

The four nurses who work in outpost settings added that the freedom and flexibility in practice fosters a sense of creativity. In the outpost, 'hands on' nursing care carries the connotation of tending a community vegetable garden, engaging young Aboriginal girls in baking bread, or cooking a huge pot of soup for the local schoolchildren's lunch, while discussing nutrition from a practical point of view. It involves working with clay and physical substances with the young people to foster an appreciation of the pleasures of creating an object with their own resources. Incidentally, this interactive style of health education also provides a forum for demonstrating

creative talents. Most impressive drawings and paintings of Aboriginal people engaging in hygienic tasks displayed one nurse's resourcefulness and artistic capability.

0.3.1.3 Wellness-oriented Nursing Care

Seven field nurses were asked to estimate the percentage of their usual week which was spent in community health maintenance, performing wellness-oriented rather than illness-oriented tasks. This category of tasks included individual and group health teaching, counselling, coordination and liaison, follow up and review activities. Replies described a proportion of wellness-oriented nursing ranging from 40 - 90%, the mean of all estimates being 75%. It was interesting to note that when the supervisor was asked to estimate the percentage for the region's entire range of nurses, her reply was 75%, a tribute to her continual interaction with the staff. Two health workers offered estimates of 80% and 66% (X = 73%), and the remainder of nurses interviewed found it too difficult to estimate the relative percentages. The sole field nurse (flying) interviewed, described her usual week as having approximately 5% of her time allocated to non-illness related activities. This

consisted primarily of health education carried out while accompanying the R.F.D.S. physicians on their clinics in isolated areas. The remainder of her time is spent in unpredictable nursing practice, usually attending to emergencies.

0.3.1.4 Educational Needs

The third question asked of each nurse interviewed, addressed the educational needs she perceived as necessary to continue in her present role. The most frequently occurring reply identified a need for more cross-cultural, particularly Aboriginal, study. Anecdotes were offered explaining how the nurses had learned by trial and error which gestures or manners of speech offended, and which were accepted by Aboriginal people. The nurses related that they had learned by experience to view the Aboriginal as a spiritual, tradition-laden individual frustrated by the white man's culture. These frustrations manifest themselves in ways foreign to European Australian interpretation, and are, therefore not encountered by many nurses in prior experience.

The second most frequently occurring response to the question of educational need concerned the nurses'

orientation to the field. Orientation is conducted in the state administration centre in Perth, and presented in a series of modules, the number of which is determined by the nurse's previous experience and the functional category in which she will be working. The usual length of orientation is six weeks. Nurses expressed general satisfaction with the orientation content, but felt that in practice, improvements in both the time and timing of the experiential portion of orientation would more adequately prepare them. Suggestions included a 'split' orientation, where one or two modules would be presented, then a short period of experience in the field would be undertaken before resuming the remainder of orientation. This change in timing of the orientation would yield more pertinent information seeking from the nurses returning to orientation, individualising the process to both the nurse and the specific area of her placement. The duration of orientation could be individualised in this system, in that the nurse would be accredited for prior knowledge and skills obtained, through a periodic evaluation throughout orientation, rather than at the completion of a set number of modules. Suggestions were made for group seminar or discussion sessions during orientation which would enable greater overlap between functionally placed nurses in the community, so that field nurses, child health nurses and school

health nurses would develop a greater appreciation of one another's roles. Further benefit would be gained from the increased overlap, in that the outpost nurse could be prepared to perform all functions in a community where she has established trust and acceptance. Reciprocally, the travel burden of an already busy school health or child health nurse would be circumvented.

The third most frequently cited need was that of education for teaching. Many field nurses found themselves in the position of educator, not just for their clientele, but for the field skills of the Aboriginal health worker. Nurses were observed to be interacting with the health workers in a helpful, nurturing way, but several of these same nurses revealed feelings of inadequacy when it came to evaluating the impact of their teaching strategies and whether they were employing accurate techniques. One nurse related that she maintains the task of health worker education by allocating it to the 40 % of her time which she spends in travel (accompanied by the health worker) each week. Another nurse put forth the suggestion that an assessment of health worker training aids be undertaken, including a more extensive utilisation of instructional videos, and further, that they be encouraged to use dictaphones to overcome

difficulties many of them have with clerical and documentation skills. A suggestion was made that the programme of health worker training involve units to be done by external studies by the health worker, replacing the present system of having the worker excused for two hours per day to attend classes at the technical college.

An educational need which also recurred in the list of those identified was that of survival skills training. Elaboration revealed that the nurses consider it of vital importance to know how to protect themselves from the elements - heat, the cold of the desert, tropical illnesses, injury resulting from alcohol related violence, and burn-out: a professional emotional depletion resulting from sustained overwork with insufficient respite. Self understanding was forwarded by an outpost nurse as a trait necessary for overcoming burn-out, and of particular importance to aid in de-roling from the hospital nursing role to the relatively unstructured community role. Anecdotes describing burn-out in the outpost setting revealed the syndrome as quite different from that experienced by the hospital nurse. Hospital intensive care and other acute care departments are fraught with nurses reaching the point of mental and physical exhaustion, and in latter years, hospital supervisors have learned to

recognise early signals of its occurrence. In the community, the field nurse (flying), leading an unscheduled lifestyle and working extended hours, many of them throughout an entire night, is particularly susceptible to stress and fatigue induced illness. In the outpost, the nurse is also at risk for such stress induced reactions as 'going bush', letting her own self care and hygiene needs deteriorate when surrounded by people who are habituated to unhygienic conditions. Outpost nurses are therefore given a mandatory special quarterly leave of one week from the outpost area to guard against fatigue and burn-out. Nurses in the region augment departmentally regulated coping mechanisms by such hobbies as painting, music, and such creative plans for early retirement as gold prospecting.

Survival skills described also include a basic knowledge of automotive repairs, particularly for the large four wheel drive vehicles the nurses operate, coupled with a working knowledge of how and where to secure repairs. Similarly, the nurse must know the roads and the airstrips, how and when to call upon which community resources for assistance in the event of a mechanical breakdown, and most vital of all, the skills for radio transmission, the radio providing a lifeline to assistance in many circumstances.

All nurses mentioned the need and appreciation of continuing education programmes, particularly those provided in the region and geared to its specific needs. In recognition of the need for continuing education, each nurse is allowed ten paid conference days per year. Other educational needs identified included knowledge of political systems, as an aid to developing the diplomatic art of getting involved but not too involved; the need for an updating of diagnostic and clinical skills, counselling skills, nutrition and cookery skills, documentation skills, skills in leading groups and knowledge of fitness and exercise. Documentation, a necessary but tedious part of the role, tends to be overlooked as a nursing function, but occupies a rather large portion of the nurses' work. The value of streamlining and condensing documentation procedures had been demonstrated to several of the nurses following placement to an outpost of a nurse with extensive prior experience in a hospital medical records department. Under her direction, techniques for more efficient data management were implemented, to several nurses' satisfaction. A closer look at the nurses' educational preparation for documentation is considered particularly necessary in the light of evolving information and communications technology.

Health workers identified the need for more interpersonal skills training and more extensive knowledge of such subject areas as alcoholism and family planning. One of the ways under consideration to accomplish continuing education for nurses and health workers alike, is the use of video as an instructional media. The regional supervisor has been exploring this option as an aid to health education in the community environment. To date, nine videos have been produced with the help of media students from the local technical college, on such diverse topics as a joint Western Australian, South Australian Aboriginal conference, a fitness class for the elderly and other community topics portraying recogniseable local residents. Video has abundant potential, according to the nurses in the outpost areas, as the Aboriginal residents are quite amenable to sitting watching videos for prolonged periods of time. The nurses, therefore, consider this to be a viable means of pictorially demonstrating healthy activities.

0.3.1.5 SUMMARY

From the interview data, a profile emerges of an ideal role model aspired to by those engaged in community health nursing. This nurse carries a broad base of diverse knowledge and the facility to communicate that knowledge at the necessary and appropriate times. Requisite skills appear to be those related to the following: assessment of client and community; time and resources management; clinical and preventive care giving; decision-making; teaching; understanding psychological, cultural and social processes; communicating with clients, community, and other health care personnel; evaluating and recording activities; surviving in a variety of physical and emotional environments; development of creative and self enhancement skills.

It is interesting to note that the nurses interviewed estimated that the majority (75%) of these activities are conducted in a wellness-oriented, or preventive context. Therefore, such illness prevention and health maintenance activities as planning, decision-making and communicating must be considered among the most important of role requirements.

It remains to determine if further skills become

evident from analysis of the questionnaire data.

0.3.1.6 The Questionnaire Data

Nursing activities reported in the survey of tasks actually performed, mirror those revealed in the interview data. As outlined in the preliminary analysis of the questionnaire, nurses in all education, experience, and functional categories are required to perform a similarly large total number of tasks per day. Despite the fact that some functional categories of nurses perform a disproportionately greater number of certain tasks, nurses in all functional categories report performing tasks of all the ten types listed. (see Figure 4). Competencies for performance of these tasks must therefore be included in the educational preparation for community health nursing. Competencies for assessment, planning, implementation and evaluation of care are essential. Competency in decision-making and organisational ability is demanded by the data illustrating that, although client need determines which tasks are performed, the majority of tasks are self-initiated. This is underlined by the relatively large number of deciding priorities tasks reported (7.83% of total daily tasks). Competencies for communicating with client, community, co-workers and

4. Problem-solving skills to assimilate and adapt a broad base of knowledge of the physical and behavioural sciences for the safe and accurate implementation of care;

5. Communication and interpersonal skills for liaison, teaching, health education, and health promotion within social, cultural and environmental contexts;

6. Evaluation skills to reassess and refine activities, and to build a scientific foundation for practice;

7. Survival skills, both physical and emotional, for coping with the external and internal environment;

8. Creative and technological skills to enhance adaptation and self-development.

These are therefore offered as the competencies which comprise the role of the CHN upon which a curriculum should be based.

0.3.2 Question Two:

What is the relationship between the community health nurses' education, experience and task performance?

0.3.2.1 Education

The majority of questionnaire respondents were those in education group 1 (R.N. only). However, group 2 respondents have the same basic preparation, the difference being that it has been supplemented with other non-registrable programmes, such as are listed in Appendix H. Together, groups 1 and 2 represent 73.96 % of total respondents. Group 4 (R.N. + 2 certificates + 1 - 9 other educational programmes), show the second largest representation (18.75% of respondents), reflecting, in part, the relatively large number of child health nurses (25.58% of respondents), who are required to have child health and midwifery certificates in addition to the basic R.N. credential. Distribution of these two and other certificates can be seen in Table 3. From the same table can be seen that eight survey participants (8.33%) report having a community health, public health or health visitor certificate. A remaining 4.17% of respondents have

only one post-basic certificate, and a small percentage (3.13%) have been prepared at the baccalaureate level. It must be noted that the number of respondents with preparation at the degree level is disproportionately low due to the fact that most nurses within the Health Department with degree level preparation, practise in supervisory or above positions, and therefore would not have been approached as potential survey participants. (At the supervisory or above level, 91.67% of staff are prepared at baccalaureate (U.G. 1) level, according to Health Department statistics for 1983.)

Analysis of variance between education groups and individual tasks, show one marginally significant difference regarding 'outcome evaluation' tasks (sig. = .0492; 4 df - Table 14). Education group 3 report a disproportionately low percentage of these tasks (2.63%), and group 4 a disproportionately high percentage (9.48%) compared to the mean percentage of 6.24% for all educational groups.

To enable closer examination of intergroup differences in task performance, education categories were collapsed into three groups, and the functional categories of field (including the two outpost nurses), child health, and school health nurses were compared.

Field nurses were distributed across the R.N. only

and R.N. + 2 certificates education groups. Those in the higher education group reported a considerably lower average daily number of direct care giving, counselling and outcome evaluation tasks, and a proportionately higher number of documentation tasks (Appendix V.i).

Child health nurses and school health nurses were distributed across R.N. only, R.N. + 1 certificate, and R.N. + 2 certificates groups. For child health nurses, those in the middle education group performed a much higher number of counselling and documentation tasks than the other two groups (Appendix V.ii). A similar comparison revealed that the highest education group of school health nurses showed a disproportionately high number of history taking, deciding priorities, teaching, documentation, and outcome evaluation tasks. The three members of this education group also reported a relatively high number of all tasks performed (Appendix V.iii). There were no consistent trends for any individual tasks which would lead to predict a linear relationship in either direction between education groups.

No significant difference was found to exist between educational groups and the total number of tasks (Table 4). Similarly, no significant difference was found between education groups and source of initiation for

tasks (Tables 16-19). However, a significant difference was found between education groups and three source of preparation items (Tables 22, 26, 27). Identification of source of preparation as 'post-diploma course' occurred most frequently from the two highest education groups (groups 4 and 5). Group 4 reported this source as 14.71%, and group 5 as 17.67%, compared to the percentage of 9.87% for all educational groups identifying this source of preparation. Identification of 'experience' as a source of preparation occurred a greater percentage of times from education group 3 (31.96% as compared to 21.27% from all educational levels). 'Books and articles' was identified as the lowest percentage of times (5.92%) by group 3, and the highest percentage of times (16.47%) by group 5, as compared to 12.28% for all educational levels (Appendix P).

Analysis revealed no apparent differences in degree of preparation ratings for educational groups.

0.3.2.2 Experience

Table 3 illustrates the distribution of respondents over experience categories. Nurses who have worked in community-based nursing 6 - 10 years represented the

largest group of respondents according to experience categories (37.50%). Those in group 2, with 2 - 5 years' experience, and those in group 4, with 11 - 20 years' experience represented the second and third largest groups (25.00%, and 22.90%, respectively). Others were group 1, those with less than two years' experience (10.40%), and group 5, with 21 or more years' experience, who represented 4.20% of respondents. The mean number of years of experience in community-based nursing was 8.31 years. As can be seen in Tables 4 - 14, analysis of variance demonstrated no significant differences between either individual tasks or the total number of tasks performed across experience groups. Likewise, analysis of variance of source of initiation (Tables 16 - 19), and sources of preparation (Tables 21 - 28) revealed no significant differences.

No apparent differences occurred in degree of preparation ratings for experience groups (Appendix T).

As was done for education groups, individual tasks were compared for field, child health, and school health nurses according to three experience groups: 0 - 2 years; 2 - 10 years; and 11 years and above. Comparisons of note included the following: Field nurses in the lower experience group reported a disproportionately low number of resources

identification and documentation tasks. Those in the middle experience group reported a relatively high number of resources identification tasks, and those in the highest group reported relatively high numbers of documentation tasks, and low numbers of direct care giving tasks (Appendix W.i).

Child health nurses in the middle experience group reported relatively high numbers of documentation tasks (Appendix W.ii). School health nurses in the highest experience groups reported a relatively high proportion of history taking and documentation tasks (Appendix W.iii).

0.3.2.3 Interpretation

Educational level does not appear to exert any significant influence on task performance, with the very slight exception of outcome evaluation tasks. It may be that this task occurs with some degree of inconsistency. Having completed a post-diploma course, as those in education groups 4 and 5 have done, corresponds predictably to identification of post-diploma course as a source of preparation. It is interesting that group 3 identified experience as the source of preparation more frequently than those in

groups 1 and 2. It would have been expected that fewer educational credentials would lead to attributing experience as the source of preparation more often than other sources. However, this same group, which also identified books and articles a relatively greater number of times than the other groups, contained only four respondents. This small sample size may have compromised representativeness. A high frequency of identification of books and articles as a source of preparation by group 5, may be related to the fact that higher education exposes one to the value of books and articles, or it may be that, because there are only three members in this education group, sample size distorted this finding as well.

The comparisons noted within the confines of the present study were intended to reveal general trends and relationships between individual tasks performed and education and experience groups. In this respect, analysis was intended to be illustrative rather than exhaustive. The findings from the present study do not present any consistent trends which would enable predictive generalisations between these variables. To determine if a relationship exists between fewer years of experience and direct care giving tasks, or increased years of experience and outcome evaluation and documentation tasks, a detailed correlational

analysis would present an interesting further investigation.

Analysis of the data suggests that the types of tasks performed are a function of the context in which a nurse practises, rather than the education or experience category to which he or she belongs. Significant differences between tasks performed by field, child health and school health nurses were found, as were differences between nurses practising in rural and urban environments. The significantly higher number of coordination and liaison skills reported by field nurses reflect a role which is centered in the family environment and demands a great many activities aimed at matching family members and resources. A higher number of history taking tasks by school health nurses reflects the nature of practice in district schools, where large numbers of screening assessments are conducted. The small numbers of follow-up and review activities performed by this same group reflects the nature of high school health practice, which demands a large proportion of direct care giving to ill or injured students, with follow-up usually attended to by parents and family physicians.

As there are more resources for referral, and the number of individuals and agencies dealing with clients is often greater in the urban than rural environment, a

higher number of referral related documentation tasks is demanded of the urban nurse. A further addition to the documentation requirement of the urban nurse is the relatively larger numbers of clients seen, and the need to keep documentation procedures updated for the benefit of other health care professionals involved with the client. Rural nurses have a more consistent clientele and appear to maintain much client and family related information with a minimum of duplication.

0.3.3 Question Three:

What is the extent of decision-making in the daily activities of the CHN in Western Australia?

As described in the interview data, the CHN enjoys a certain degree of independence in practice. Decision-making was observed and reported in the interviews as a cooperative process, with client care needs the single most important determinant of how individual nurses organised their activities. Decisions to initiate and prioritise activities were, however, determined primarily by the nurses rather than a supervisor, client, or other. In that respect, contextual constraints were minimal, allowing nurses a relatively high degree of independent decision-making.

As shown in Table 15, 83% of all tasks were reported as self-initiated. Of the 17% remaining, clients initiated 11.04%, other sources (including family, teachers and other health care personnel) accounted for 4.09%, and supervisors were identified as initiating 1.87% of tasks.

When the figures are distributed over functional categories, (see Appendix L) the frequency of tasks in source of initiation categories is relatively similar to the total population sampled, with three

differences. Analysis of variance reveals firstly, a higher urban than rural percentage of tasks categorised as 'self-initiated' (sig. = .0255; 1 df - Table 16). Secondly, rural nurses categorised tasks as 'supervisor-initiated' more often than urban nurses (sig. = ,0402; 1 df - Table 17), and as a higher percentage of sources of initiation identified (.0402; 1 df). Thirdly, the percentage of field nurses categorising tasks as 'other-initiated' was higher than other nurses (sig. = .0259; 3 df - Table 19). Analysis of variance for education and experience groups revealed no significant differences in sources of initiation identified.

The relatively greater number of supervisor-initiated tasks for rural nurses may be a reflection of the fact that, according to the Health Department (Planning and Review Section), rural nurses tend to have a higher turnover rate than urban nurses. Although a respondent could be categorised as having many years of experience in community-based nursing, she or he may have been in the present location for only a short time. Including a survey question on years of experience in the present position would have provided insight into this relationship between job mobility and supervisor-interaction relating to initiation of tasks.

It is not surprising to learn that field nurses perform relatively more other-initiated tasks, as the role requires more acute care home visits, which are often requested by family or other health care personnel. This cannot be considered to relate to either the capability or inclination for self-decisioning, as client need in these cases, supersedes the nurse's organisation of task performance. It must also be noted that the numbers of supervisor-initiated (1.87%) and other-initiated(4.09%) tasks are small relative to all sources of initiation. Caution in interpreting these findings is therefore necessary to prevent a distortion of the initiation of tasks data.

Deciding priorities, as mentioned previously, was the fifth most frequently occurring task overall, representing 7.83% of total daily tasks, with no significant differences evident between functional, education, or experience groups. This relatively equal distribution indicates that decision-making and prioritising is demanded by the community health nursing role, independent of preparation or the specific functional category in which it is practised. The definition of primary care nurse as decision-maker is thus supported.

Assessment of such a pervasive part of the community

health nursing role as decision-making is restricted by measurement procedures and the difficulties associated with dividing integrated nursing tasks, which may each have a decision-making component, into discrete units. However, the information provided by study participants confirms the fact that decision-making occupies a relatively large portion of the community health nurse's performance requirements. The capabilities associated with decision-making are consequently a vital component of community health curricula.

0.3.4 Question Four:

Do existing educational curricula adequately prepare for required practice performance in community health nursing?

To address this research question, existing curricula must be examined in reference to information provided by those engaged in the performance of community health nursing, and those engaged in the educational preparation of community health nurses. The section to follow is based on details of practice performance supplied by community health nurses, and details of educational preparation supplied by personnel from the School of Nursing at W.A.I.T. and the Staff Development Unit, Health Department of Western Australia.

0.3.4.1 The W.A.I.T. Nursing Curriculum

As explained in chapter two, nursing education is, with Commonwealth government sanction, moving into the tertiary education system over the coming five years. The sole tertiary level nursing curriculum in Western Australia which therefore needs to be examined, is that offered at the W.A.I.T. School of Nursing. This curriculum provides a pre-registration (U.G. 2) six

semester programme leading to a Diploma of Applied Science (Nursing), and registration for nursing practice; followed by a conversion programme leading to a U.G. 1 Bachelor of Applied Science, with the addition of one semester The diploma level programme provides a broad generalist core as preparation for nursing practice. The programme for conversion of the diploma to baccalaureate level has a structure which incorporates common core units with one of four streams: advanced clinical nursing, nursing administration, nursing education, and primary health care. The primary health care stream is the one which prepares the nurse for community health nursing. It replaces the previous certificate in community health nursing which was formerly available to registered nurses following one year of full time post graduate study. In order to encourage the student to view community based nursing and primary health care as an integral part of the nurse's role, a blend of relevant content and clinical experiences are included throughout the basic course. In first year, the student is introduced to the concept of community assessment and applies this in relation to the care of the elderly. In second semester, the child and family module is community oriented, and the student gains experience in a variety of settings, including the home situation. The focus of care in second year is on the

individual in the acute situation, but outreach into the community is encouraged by means of post-discharge home visits and placement with hospital-based visiting nurse services. This aspect of the curriculum receives a major emphasis in third year. (W.A.I.T. Submission for Accreditation of Awards for the Institute, 1983).

In the primary health care module, related concepts are further developed, and students are provided with the opportunity to select two placements which are of interest, and which will provide the learning experiences to meet students' identified objectives. If primary care is identified as an area of interest, the student may undertake clinical options in a primary care placement in one or more of approximately ten available community agencies, including Community and Child Health Services. By way of accommodating nurses with home and work responsibilities, as of 1985, one-half of the required units for the Bachelor of Applied Science (Nursing) degree will be available by external studies from W.A.I.T., and through contractual arrangements with community colleges established at Hedland and Kalgoorlie, and to be established in Albany and Bunbury.

In the nine year history of the School of Nursing at W.A.I.T., course evaluations have resulted in modifications to the original curriculum such that the present one appears to correspond to a large proportion

of declared learning needs of course participants, as evidenced through recent course evaluations. (Watt, R., Acting Head of School of Nursing, W.A.I.T., Personal Communication, Sept. 6, 1984).

0.3.4.2 Health Department Continuing Education Curriculum

The Health Department of W.A. Staff Development Unit provides a continuing education curriculum for all nurses in the department, based on recommendations from both staff development personnel and the nurses throughout the regions. The major portion of this curriculum is provided at the annual inservice week, held in Perth each year. The department accommodates and encourages as many nurses as possible to attend both joint and concurrent sessions tailored to the specialised needs of field, child health, school health and outpost nurses. In addition, educational sessions are conducted throughout the year in each region. Presentations by Health Department educators are supplemented by those provided by interdisciplinary local experts. An attempt is made to provide as many sessions as possible to all regions, but, because of staffing limitations, some uneveness of services is experienced throughout the regions.

Further inputs to the continuing education curriculum are arranged through functional groups of metropolitan Perth nurses, and through the regional centres. Urban child health, school health and field nurses schedule seminars on a variety of topics relevant to their individual needs, and as speakers become available. These sessions enhance regular district meetings. Regional supervisors schedule similar seminars when the opportunity of bringing nurses in the region together with available speakers presents itself, as a supplement to their regular regional meetings.

Outlined in the discussion to follow, will be those inservice provisions of the past twelve months and components of the W.A.I.T. nursing curriculum which directly relate to the tasks performed by survey respondents. Tasks are detailed in order of their reported frequency of occurrence.

0.3.4.3 Documentation Tasks

Documentation tasks include all those clerical activities involved in compiling and transmitting client information and related nursing assessments, plans, care giving, and evaluation. As can be seen in Table 3, the most frequently occurring task was

reported as documentation (21.29% of total daily tasks). Analysis of variance for documentation tasks across education and experience categories shows no significant differences (Table 13). Documentation tasks are relatively similarly distributed across functional categories with the exception of the rural/urban comparison, where rural nurses reported a fewer number (sig. = .0006; 1 df), and percentage (sig. = .0209; 1 df) of documentation tasks. The burden of documentation was the subject of fourteen open ended comments. A comment typifying those regarding documentation stated: "The most stressful part of the work is paperwork. It limits [time spent on] client care." Several comments addressed the need to streamline documentation procedures, and four respondents issued a plea for knowledge of "how to use computers in the field."

Personal visits to clinics witnessed that considerable duplication of information is required of nurses. All nurses observed keep appointment records, referral and individual client records, and summary records for statistical purposes. In some cases, records referenced by client conditions and, for itinerant people, by geographic locations are kept. In addition, child health nurses complete detailed growth and development records for the mothers to retain.

School health nurses complete screening and student medical history records on all school children, and complete reports for the schools or department for which they work in addition to Health Department records. Additionally, reports on individual children are often completed for parents and physicians. Added to the outpost and field nurses' usual documentation burden, are the client reports written specifically for other health care personnel and/or agencies working with the client or family.

The curriculum at W.A.I.T. provides instruction throughout the six semesters of the diploma course on traditional necessary elements of documentation. Instruction is given on the accuracy of report writing for statistical information; the language and terminology used, to maintain universal understanding in medical communications; and comprehensiveness of reporting, for the purposes of accountability and legal protection. However, the emphasis is placed on individualising recording systems. Students are challenged to devise problem-oriented client recording systems tailored to the pertinent needs of the client or aggregates with whom she or he is working.

No provision is made for teaching modern information technology systems or computing to nurses in the diploma level curriculum, although the subject is

addressed in relation to integrated communication skills throughout the course. Computing and data analysis are, however, a subject area provided for in the baccalaureate level programme. Documentation procedures for the specific requirements of the Health Department are detailed for the nurses during orientation to the field. As in most public service departments, a separate information systems department designs and prescribes the procedures, and little input regarding possible modifications to existing systems is received from nurses. In addition, data collection and documentation updates are provided as necessary. For example, in the past twelve months, inservice sessions have been held in the Pilbara, Goldfields, and metropolitan Perth, to discuss new health records and care plans. Some inadequacy is apparent in educational preparation for documentation in that a performance requirement of such high frequency would appear to demand instruction in information systems technology at the undergraduate level.

0.3.4.4 History Taking Tasks

History taking and client assessment skills comprise the major assessment component of the nursing process, as the key to identification of client needs. The

second most frequently occurring task was reported as history taking (20.28% of total daily tasks). Analysis of variance of history taking across functional categories of nurses revealed significant differences. Predictably, school health nurses, whose role demands the largest number of screening assessments, performed the greatest number (sig. = .0017; 3 df), and percentage (sig. = .0001; 3 df) of history taking tasks. No significant differences were evidenced over education or experience groups.

Of all identified needs for continuing education or previous education, none specified assessment or history taking skills. However, keeping updated on medical conditions, including sports and trauma induced injuries, for purposes of client assessment, was the second most frequently reported continuing education need (19.17% of all reported needs), and third most frequently reported need for previous education (6.38% of all reported needs). A further need for both continuing (3.11%) and previous education (5.85%), identified greater knowledge of nursing studies - theory. Such needs were explained as the knowledge of growth and development and normal body functioning for purposes of maximising client assessment skills.

History taking and assessment skills are taught as a stream of nursing skills in the W.A.I.T. diploma course

in the first, second, third, and fifth semesters. The curriculum includes assessment by physical examination, observation and interviews with individuals and aggregates, at increasing levels of complexity. In addition, Health Department inservice sessions at Kununurra, the Goldfields, the Pilbara and Perth over the past year have provided updates on vision screening, clinical conditions, assessment of scoliosis and heart murmurs in children, and assessment of geriatrics and the disabled in outgoing communities. Further, community assessment was the subject of inservice presentations in both Perth and the Goldfields, as a portion of the year's continuing education curriculum. It would appear, therefore, that adequate provision is made for this performance requirement in the present curriculum.

0.3.4.5 Teaching Tasks

Client teaching is a vital component of the nurse's role in the acute care, or illness-oriented context. In the community health nurse's role, however, teaching activities assume an added dimension. The philosophy of promoting self-care and self-responsibility dictates that the CHN develop expertise in teaching the rationale and methods of self-care to the client.

Teaching skills are also required for health education and health promotion at the community level. Additionally, for those responsible for Aboriginal health worker training (field and outpost nurses), and for those functioning as preceptors for the W.A.I.T. primary care students assigned to their clinics during the experiential portion of their course, instructional techniques are a necessity.

Teaching occurred as the third most frequently required task (11.30% of total daily tasks). No significant differences were found between teaching tasks and analysis of variance with functional, education or experience categories. Teaching techniques were identified as 4.66% of those identified for continuing education, and 2.13% of all identified needs for previous education.

Preparation for teaching in the W.A.I.T. curriculum includes an introduction to learning principles taught in the behavioural science portion of semester one, and health teaching for individuals, and the application of teaching/learning to client education in semester two. In semester five, the subject of self-directed learning is addressed, and in semester six, health teaching in groups is taught. The 1984 sessions provided at the annual Health Department inservice week included preceptorship, the use of audio-visual teaching aids,

and health worker training. Sessions on teaching techniques were also provided this year in the Goldfields, the Pilbara, and Geraldton. That the need for teaching skills exists seems apparent from the attention afforded this subject in both curricula. Adequacy of preparation for teaching is somewhat compromised by the inability to provide sessions addressing this subject in all regions.

0.3.4.6 Direct Care-Giving Tasks

Direct care-giving, implementation of a nursing care measure, ranked fourth in frequency of all daily tasks reported (10.94 %). No significant differences were found through analysis of variance of care-giving tasks and education or experience groups, but a difference was found between functional categories, with school health nurses performing a higher percentage (sig. = .0304; 3 df) of care-giving tasks (Table 8). Case by case analysis revealed that high school nurses provide direct care with greater frequency than other nurses. Typical activities include administering first-aid to injured students, and treating minor medical complaints. Practise in community and clinical nursing was identified as a need for continuing education (5.7% of total identified needs), and previous education

(13.83% of total identified needs).

As preparation for care-giving derives from both curriculum input and experience, the curriculum at W.A.I.T. is designed to allow practical experience at the time appropriate to achieving competence in those skills being taught at the theoretical level. The 'nursing' and 'nursing skills' streams provide theory, demonstration, and simulation, through classroom lectures, videotapes of procedures, and role playing methods. The curriculum designates 800 field and clinical experience hours to each student over the six semesters. These hours are, however, experienced as a student, and therefore lack the situational complexity of responsibility for client care which nurses claim as necessary in such comments as: "Experience is the true teacher"; "Experience is the reason for success in practice"; "Knowledge and skills for school health come from experience, not training". If such statements on the value of experience (5.51% of all comments given) accurately reflect need, curricula with a stronger experiential component would appear to be what nurses are requesting as educational preparation for direct care giving. A pre-service curriculum inadequacy cannot be implied, however, as the provision of experience with responsibility for client care would severely compromise the safety and accuracy of care.

Inservice sessions held throughout the past year on direct-care giving issues have included nursing for specific paediatric conditions; cancer care; resuscitation; dialysis and intravenous techniques, all provided during the annual inservice. In the regional centres of Kununurra, Derby and the Pilbara, topics such as endemic disease intervention, and specific paediatric conditions, were presented to aid care-giving expertise. Any inadequacy in the continuing education curriculum would therefore be a result of inaccessibility to the presentations, rather than in the content provided.

0.3.4.7 Deciding Priorities

The fifth most frequently occurring task was that of deciding priorities, an organisational aspect of nursing practice. Analysis of variance of deciding priorities tasks across education, experience and functional groups of nurses failed to reveal any significant differences. This particular task was not identified as either a need for continuing or previous education.

In preparation for such organisational skills as prioritising activities, the nursing process

problem-solving approach is presented in the first semester of the W.A.I.T. curriculum. Following three semesters providing a broad behavioural sciences and nursing studies base, an introduction to conceptual nursing modules is presented. This unit includes a component of organisational aspects of nursing care delivery. Team functioning, leadership, and group dynamics are then offered in semester five, in a tutorial/participative workshop style, to aid in synthesizing theoretical information on decision-making and prioritising activities. The additional contributor to management and organisational skills, is considered to be the experiential input. Continuing education sessions in decision-making this year included professional development sessions on managing work, provided at Kununurra, Derby, the Goldfields, and the Pilbara. The curricula therefore, would seem to adequately address the subject of decision-making, at least to the extent where a basis for experience is provided.

0.3.4.8 Counselling Tasks

Counselling clients in a home, clinic, or school situation is a complex task requiring several integrated skills. The client with an identified need

for counselling is referred to a trained counsellor in most situations. However, because of familiarity, and the care-giving nature of the relationship with the CHN, it is from the nurse that clients often choose to seek help for counselling needs. The role of counsellor, is thus frequently ascribed to the community health nurse.

Nurses reported having performed counselling tasks as 6.48% of total daily tasks. Care must be taken to avoid the misperception of counselling tasks as a relative proportion of total daily performance requirements however, as the time demands of each counselling session are much greater than most other tasks. No significant differences were found between these tasks and education or experience groups, but analysis of variance demonstrated a difference in average numbers (sig. = .0510; 3 df), and the percentage (sig. = .0062; 3 df) of counselling tasks across functional categories (Table 10). School health nurses reported fewer counselling tasks, but case by case analysis revealed that the distribution was skewed by the district (primary) school nurses who perform a negligible number of counselling tasks, compared to high school nurses.

Counselling and related human relations skills were the most frequently identified need for both continuing

education (22.80% of the total), and previous education (29.26% of the total). The issue of counselling was addressed in open ended comments. Several nurses referred to the difficulties of counselling during busy clinics. Child health nurses claimed that they could run parallel clinics for marriage counselling and personal development. High school nurses drew attention to the fact that they are called upon to provide considerable counselling to teachers as well as pupils. One such nurse remarked on the insecurity involved in providing counselling with no previous training, and having continual concern over the outcome of counselling strategies.

In preparation for counselling, the W.A.I.T. curriculum includes behavioural science as a major disciplinary area with component units designed to assist the student to understand psychological, sociological and cultural processes common to individuals, groups and communities. Each of the six semesters contains a behavioural science unit covering such areas as developmental psychology, social behaviour, basic psychological processes, behavioural analysis, group dynamics, emotional disorders, and concepts of community social networks.

Continuing education components which contribute to preparation for counselling have included family

planning issues at Kununurra, and cross-cultural seminars at Geraldton, the Goldfields, and the Pilbara. At the annual inservice week, women's health issues, use of retirement and leisure time, remarriage and step-parenting, care of the bereaved, family planning, and the nurse's role in counselling were offered. The volume of information provided in both curricula would therefore, appear to adequately meet educational needs. The fact that needs for counselling and related skills received such high priority in the nurses' opinions, however, points to the fact that some provision must be made to improve the delivery of counselling skills training to those already in practice.

0.3.4.9 Resources Identification Tasks

Resources identification is the task which requires the CHN to match community resources to client need. Resources identification tasks represented 6.83% of total daily tasks performed. No significant differences were revealed by analysis of variance between resources identification tasks and education, experience or functional categories. Resources identification represents an integral part of community liaison skills, which were identified as 4.15% of total

needs for continuing education, and 4.79% of total needs for previous education.

The W.A.I.T. curriculum incorporates resources identification into the nursing skills stream. Discharge planning, which includes elements of resources identification, namely community and client needs assessment skills, is introduced in semester four. In semester five, health team group skills emphasize resources identification, and in semester six, nursing skills and coordination of care are expanded to the community level.

The subject of resources identification was provided by the Health Department during the past year within the context of working in a community setting, and presented at Kununurra, Derby, the Goldfields, Geraldton and the Pilbara. The annual inservice session in Perth provided joint sessions on community assessment which included resources identification, and a school health nurses' session on identifying specific resources in the community related to their requirements. It would seem, therefore, that adequate provision is made for resources identification in existing curricula.

0.3.4.10 Follow-up and Review Activities

Follow-up and review activities include such assessment, liaison, documentation and communication tasks as are necessary to complete client care or evaluate a course of action for the future. In this category, would fall all client assessment visits subsequent to the initial visit, telephone calls to determine outcomes of recommmendations, and any fact finding activity planned as a review of care or a health education communication. Follow-up and review activities represented 5.44 % of reported total daily tasks. No significant differences were found between this task and education or experience categories. Analysis of variance did, however, demonstrate a lower percentage of these tasks reported by school health nurses (sig. = .0038; 3 df - Table 12). Research methods were identified as frequently as 3.11% of continuing education needs, and communications skills were identified as a need for both continuing and previous education, included in counselling and related skills. Both of these needs would enhance performance of follow-up and review activities.

The nursing studies stream in the W.A.I.T. curriculum provides instruction on follow-up and review activities as part of the evaluation component of the nursing process, in semester one and two, and in semester six,

which deals with community and primary health care. In semester five, intra and interpersonal communications skills are offered. Also in semester six, the nursing skills and behavioural science streams provide units on epidemiology and consequences of nursing interventions, as well as the effects of social and environmental factors. These issues are fundamental to follow-up and review activities. One aspect of client follow-up, namely, non-compliance, was presented at an inservice session in Geraldton during the past year. The nursing process, and its component parts, as mentioned previously, was presented in one of the Goldfields' continuing education sessions. It would appear that some inadequacy exists in applications of research methods to practice, implied by the identified need for such studies. However, the existing pre-registration curriculum appears to provide for systematic follow-up and review activities. In addition, it appears that little emphasis has been placed on this topic in the continuing education curriculum, as only sporadic provisions have been made for inservice sessions on follow-up and review activities.

0.3.4.11 Outcome Evaluation Tasks

Outcome evaluation activities are those which the

nurse performs in order to decide the merit of a nursing implementation for a client or aggregate. Depending upon the evaluation, the nurse may consider the case completed, may pursue a further course of action, or may revise procedures and approaches to client care. Outcome evaluation tasks were performed a reported 4.47% of total daily tasks. Analysis of variance revealed no significant differences between the occurrence of this task and either functional or experience categories. A marginal difference was found in percentages between outcome evaluation and education groups (sig. = .0492; 4 df - Table 14). Education group 3 (with one post-basic certificate), reported a disproportionately low percentage of outcome evaluation tasks, and education group number 4 (with two post-basic certificates) reported a higher than average percentage of outcome evaluation tasks.

The need for knowledge of research methods, as mentioned in the previous section, was identified as 3.11% of needs for continuing education. Outcome evaluation would, by definition, be enhanced by a knowledge of research methods.

The evaluation stage of the nursing process receives equal emphasis with assessment, planning and implementation in the W.A.I.T. curriculum during semesters one and two. In addition, instruction in the

scientific method, which is begun in semester one, and concentrated in nursing science in semester four, prepares for research and evaluation activities. The 1984 inservice session in the Goldfields dealing with the nursing process and the session on nursing in the community offered during the annual inservice week also addressed the issue of outcome evaluation. Adequacy of content, therefore, seems apparent, with a greater distribution of sessions presenting the most important potential improvement.

0.3.4.12 Coordination and Liaison Tasks

Coordination and liaison tasks include organisational activities aimed at efficient functioning of client care: conducting enquiries, making referrals, allocating resources and communicating with the client and/or others in the community. Activities such as personal visits, talks, or written communications which promote the role of the community health nurse, are included in this category of task. These activities were identified as occurring 3.71% of total daily tasks. No significant difference was found between coordination and liaison tasks and education or experience categories, but analysis of variance did reveal a higher percentage of field nurses performing

these tasks (sig. = .0457; 3 df). Skills for community liaison were a frequently identified need for continuing education (4.15% of those identified), as well as for previous education (4.79% of those identified). Open-ended comments on the subject of communicating with the community explained the importance of accurate communication, particularly to parents, teachers and those individuals who may be apathetic to health related messages.

As mentioned under preparation for follow-up and review activities, the nursing skills stream in the W.A.I.T. curriculum provides a communication component in each of the six semesters. It covers interview skills, writing, and personal communication in all nursing settings, from the client to the aggregate level. Coordination of care is presented throughout the same stream from the simple to the complex situation. Related to liaison activities, inservice presentations at Kununurra, Derby, and the Goldfields included community intervention procedures, work aspects of the Department of Community Welfare, and integrated health services. Annual inservice presentations for 1984 also included the topics of medicare and the family court services. Preparation for coordination and liaison activities would therefore seem to be adequate in the present curricula.

0.3.4.13 Curriculum Components Not Related to Individual Tasks

Respondents identifying needs for continuing and previous education cited several needs which, although not strictly related to tasks, were identified as essential to nursing practice. These are detailed below.

Stress Management and Coping Skills

The most frequently cited of these needs was the need for coping skills and stress management (6.22% of total identified continuing education needs and 4.79% of total identified needs for previous education). That the job is stressful was also mentioned in 2.12% of open ended comments, which issued pleas for appreciation of staff stress levels and provision of ways to cope with the "psychologically draining" aspects of community health nursing. Stress and adaptation and stress management are topics addressed in the third and fourth semester in the behavioural sciences stream of the W.A.I.T. curriculum. Coping skills and stress management was also the subject of inservice sessions in the Goldfields and Geraldton in 1984, and during the annual inservice sessions in

Perth. It would appear that there needs to be a more uniform provision of stress management sessions to the regions.

Information Sharing

Information sharing with other nurses was identified as 4.66% of continuing education needs. The need related to the opportunity as well as the strategies for sharing with contemporaries, as evidenced in the comment: "Community health nursing can be an isolating experience. We need strategies for sharing and involvement. Support networks to improve service delivery are important." Nurses identifying this need appear to either consider inservice sessions, district meetings and meetings of functional groups of nurses insufficient for their sharing and networking needs, or are working within a circumstance which makes attendance at these sessions difficult. A related issue was commented on as a condemnation of the fragmentation of services which occurs because of nursing services being provided by three specialist services (field, child health and school health nurses), rather than one family centred generalist community health nurse. A greater degree of information sharing was considered by this respondent to be a potentially positive step toward decreasing service fragmentaion.

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Education

The subject of further education was one which occurred in the need for continuing education, previous education and open ended comments portion of the survey. Respondents identified the need for time off to attend courses as 4.15% of the total identified continuing education needs, and 3.19% of total identified previous education needs. In addition, the need for tertiary level education was identified as 2.13% of all previous education needs. Among education needs specified, was the need for interdisciplinary studies (2.59% of continuing education needs, and 2.13% of previous education needs.) Comments typically requested "interdisciplinary educators".

Interdisciplinary studies are provided in the W.A.I.T. curriculum. Common core study units provide interaction opportunities to health sciences students. Nursing students currently enrol in common first year Human Biology units and a wide range of free electives. In future, a health sciences communication study unit will be offered as one of these electives, and will provide learning experiences with an opportunity for interdisciplinary interaction. The continuing education curriculum retains an interdisciplinary studies approach in attempting to

provide a wide range of topics from local and visiting experts.

Orientation to the field, provided by the Health Department, was the subject of 3.81% of all open ended comments, and primarily expressed the need for relevancy in content. Several nurses recommended a split orientation, with part of the modules presented after the nurse had spent time in the area he or she was being prepared for. Fragmentation of services was also addressed in relation to orientation. Comments urged more exchange of information between functional categories of nurses through seminar type opportunities at orientation. The need for cross-cultural studies during orientation was also commented on. The suggestion was put forth that Aboriginal educators should present relevant modules to the nurses to prepare them for communication with the Aboriginal clients with whom they would be dealing. The other topic of comments on orientation regarded family planning and sex education. Those mentioning these subjects agreed that they needed more advanced preparation for counselling on family planning, and sexuality discussions, particularly in the high school setting. These specific topic areas therefore, present content inadequacies in the present curricula which must be examined for future curriculum planning.

Access to education was the subject of 4.29% of open ended comments, the majority of these expressing a desire for correspondence or external studies courses, and financial assistance. Citing the difficulties of combining the housewife/mother/nurse role, nurses offered comments on the overwhelming time constraints in attempting to continue their education. Time off from nursing duties to pursue further education was identified as 4.15% of total continuing education needs, and 3.19% of previous education needs. These needs are being attended to by educational planners at both W.A.I.T. and the Health Department. As mentioned previously, as of 1985, one-half of the baccalaureate level nursing courses will be available externally to senior R.N.'s. The Health Department offers small scholarships to nurses attempting to upgrade academic qualifications, and disbursed two $2000.00 scholarships during the past year.

Role Related Topics

Role related topics, which included those specific skills relative to the performance of either field, outpost, child health or school health nursing, was identified as 3.63% of continuing education needs, and 5.32% of previous education needs. The open ended comments which related to these needs included twenty three comments elaborating the specific role

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requirements of the CHN, and a further 40 comments relating to the specialised needs of the school health nurse. Common themes included the need for realistic preparation for community health. Several nurses emphasized the fact that a greater understanding of the diversity of the job, and the process of de-roling from the hospital-oriented role needs to be clearly and accurately explained. The need for a knowledge of practice in country towns, including the fact that the nurse is "on-duty for queries at social outings, and during shopping"; a knowledge of "rural-style politics", and the "travel burden in rural areas, including transporting clients", were among comments relating to the role. School health nurses' comments provided the insight that the role of the nurse in a school is poorly understood by school authorities, teachers, families, and other health care professionals. A solution offered in one nurse's comment is to promote the nurse's role as a resource person, to help teachers overcome opposition to the image of the nurse as either a teacher or a nurse, but not both. Other role related topics included comments on the difficulties of dealing with substance abuse in the schools, and the need for more knowledge in that area; the field nurse's need for group leadership skills, and the need to be relieved of some of the responsibility for health worker training. These

subjects are among those which are presented during orientation. As mentioned in chapter two, orientation to the field consists of a number of modules which vary in content and duration with the nurse's education and experiential background, and the functional setting for which he or she is being prepared. Cultural issues, survival skills, and departmental methods of documentation are among the topics which supplement clinical assessment skills and screening techniques. In the nurses' opinions, orientation adequacy could be improved by the addition of the role related subject areas specified.

0.3.4.14 Summary

The foregoing section reveals that widely diverse skills are required of community health nurses in all functional settings. As evidenced from the needs identified, each type of task required of the nurses demands a complex body of knowledge; and each, in turn, requires organisational skills to enable the CHN to meet adjuvant client, community, personal and professional needs. The curricula for both preparation for practice and continuing educational needs provide for essential competencies previously defined; namely,

1. Diagnostic and clinical skills for assessment of client and community;

2. Skills for decision-making, priorising, and planning;

3. Skills for management and coordination;

4. Problem-solving skills to assimilate and adapt a broad base of knowledge of the physical and behavioural sciences for the safe and accurate implementation of nursing care;

5. Communication and health promotion within social, cultural and environmental contexts;

6. Evaluation skills to reassess and refine activities, and to build a scientific foundation for practice;

7. Survival skills, both physical and emotional, for coping with the external and internal environment;

8. Creative and technological skills to enhance adaptation and self-development.

Of the total respondents to both questionnaires, 141 (97.91%) were educated below the tertiary level, presumably in hospital-based schools of nursing. Judging from the survey data which reveals experience as the most frequently identified source of preparation

(21.27% of all sources identified), and the number of comments (13) underlining the vital contribution of experience to the nurses' perceived degree of competency, it can be assumed that, at least in their opinions, many nurses did not begin practice with adequate preparation. The current pre-registration and continuing education curricula appear to be adequate insofar as they contain most essential elements necessary to prepare for community health nursing. A further acknowledgement of the impact of the continuing education curriculum is manifest in the relatively large proportion (17.61%) of identification of inservice as a source of preparation for task performance. However, subject areas which appear to inadequately provided for include family planning, sexuality, substance abuse, Aboriginal culture, group leadership skills, and health worker training. In addition, educational preparation in such interdisciplinary areas as information systems technology, and community political systems, would provide a broader operational base from which to practice, ultimately resulting in more adequate preparation for achieving client care goals in the community-based context. Despite systematic planning and vigilant revision of content, the most striking deficiency remains that of inadequate service delivery. Accessibility to the curricula, and

consistency of presentation emerge as the important potential improvements to future educational programme planning.

0.3.5 Question Five:

Could the survey instrument be used to identify task performance requirements of other groups of nurses?

The survey questionnaire was designed to elicit much detailed information on the nurses' daily tasks. In addition to categorising the number of tasks performed on each survey day according to the ten task categories provided, participants were asked to report the source of initiation of each task performed, and to assign a rating to their perceived degree of preparedness for the tasks required of them. Further, they were asked to forward an opinion on which source or sources best prepared them for task performance.

0.3.5.1 The Task Categories

As evidenced in Table 3, all ten task categories provided in the survey form were utilised by outpost, field, school health and child health nurses, to varying degrees, illustrating a general measure of usefulness. Some participants seemed to encounter no difficulties assigning tasks to categories. Others found the survey overwhelming, relating that the process of categorising steps which are habitually

performed in a unified manner, impinged upon their time. This was reflected in such comments as:

> "Too much time is spent on evaluations instead as getting on with the job", and "The survey is causing me stress - time, not willingness is a factor".

Conversations with nurses through both telephone enquiries and personal clinic visits revealed that the ten task categories were relevant to tasks performed by them. However, this applicability of the instrument became apparent to some participants only after discussion and elaboration of their individual nursing activities. Difficulties in using the instrument to categorise tasks appeared to arise from attempts to identify discrete steps of the problem-solving process in task performance. Apportioning nursing care into tasks represents a reversal of the comprehensive, holistic view of the individual in wellness and illness which is a philosophical tenet of community health nursing. It became evident from the nurses' enquiries that, although the terminology and principles of the nursing process steps of assessment, planning, implementation and evaluation had been previously presented in inservice sessions, few recipients of this information had adopted the process as a method for conceptualising actual practice performance. This fact was borne out at the annual inservice education session on quality assurance in nursing care, conducted during

the study period. Following a workshop attended by approximately 50 Health Department community health nurses, the course leader reported that discussion with this group revealed a general lack of comprehension of the applicability of the nursing process to their usual nursing care. (Bedford, J., Health Department of W.A., Personal Communication, August 17, 1984).

Citing numerous books on the process and its components, Maria Phaneuf (1980) reports that usage of the nursing process is no more frequent elsewhere:

> "The nursing process is generally accepted as the modality of nursing but is not regularly used...The amount of literature suggests that nurses have not come to terms with the use of the nursing process. Problems with teaching it are apparent in education settings - they are expressed or implied in differences in perspectives held by some nursing educators and some administrators of nursing service." (p. 125).

0.3.5.2 Particularities of Task Performance

Some difficulties were encountered in categorising individual tasks as 'counselling' rather than 'teaching', and categorising 'outcome evaluation' rather than 'follow up and review activities'. In reply to enquiries, explanation of teaching as instruction, and counselling as an in-depth

problem-oriented communication helped to clarify the first difficulty. Distinction was made between a follow-up and review activity as an assessment and/or implementation of care subsequent to the initial assessment, and outcome evaluation as an evaluation of a nursing implementation already undertaken.

Few difficulties were reported allocating source of initiation of tasks to self, supervisor, client or other categories. As illustrated in Table 15, the majority of tasks in all community health settings encountered are initiated by the nurse as a function of the role of primary care provider. Rating degree of preparedness and perceived source or sources of preparation for task performance also appeared to present few difficulties. The additive effect of requesting this information, and that from the open ended portion of the survey, which many nurses responded to with thoughtful, elaborate comments, did however, present a considerable response burden.

0.3.5.3 Implications for Further Research

To ascertain the competencies which comprise the role of the CHN, a measure of tasks performed is necessary. Insofar as the nurses surveyed were able to categorise

nursing tasks required of them in a typical day, and relate information on the source of initiation and perceived degree and source of preparation for task performance, the list is adequate and would lend itself to studies replicating the current one.

For the CHN in a situation demanding a significant amount of travel however, the list is somewhat limited. It is difficult to categorise a trip to or from a home, school, clinic or mission as a task. Outpost and rural field nurses described a typical day, in response to questionnaire number two, as involving elaborate preparations for travel the following day. These included automobile maintenance, referral and resource allocation to facilitate substitution of services in their absence, obtaining survival equipment and supplies for the journey's anticipated medical requirements, and, as described by one nurse, preparing to "run an office from the boot of your car".

School health nurses in both rural and urban environments reported not only travel between schools, as many of them serve more than one school in a day, but also transfer of students in their own vehicle, to either home, hospital, or locations for further care. Assessing the number of trips, or the volume of kilometers travelled would not seem to provide an accurate reflection of either the time demands, the

complexity of travel preparations, or the trip itself.

The competencies derived from the travel portion of the nurses' performance requirements merit careful study. Certainly, ability as a driver is a prerequisite for community health nursing. Additionally, a sound knowledge of survival skills, automobile maintenance, navigating in country areas, and skills for radio operation are essential curriculum components. Needs assessment of travel demands as an addition to the original task list, would therefore enhance its usefulness in preparing for performance related research on other populations of nurses.

Perhaps the most vital improvement would be to limit the survey to those who can be exposed to personal and consistent introduction of its method. The presupposition that familiarity with the nursing process would permit a degree of facility in translating tasks into the component steps of the process, has been found to be in error. In its present format, the questionnaire is therefore a useful, but not ultimate measure of task performance.

A series of controlled, consistently delivered instructional sessions on completing the survey, delivered to a proportional, stratified sample of community health nurses in all education, experience

and functional categories, would yield a higher degree of accuracy of comparative data on task performance requirements than the present, mailed questionnaire. Given this change in presentation, the instrument could be utilised to compare community health nursing tasks in the other states of Australia, in other countries, or among other categories of community health nurses. An interesting, and as yet under-researched example would be in the field of occupational health nursing, where little is known of the nurses' required activities, a high degree of isolated decision-making takes place, and curriculum development for this specialty area is in its infancy.

0.3.6 Question Six:

What recommendations arising from the data can be made regarding recruitment and educational programme planning for community health nursing?

0.3.6.1 1. Recruitment

i)Recruitment for Community Health Nursing Programmes.

Applicants for community health nursing must be selected on the basis of their having aptitudes considered to be important in the development of competencies expected for practice. Standardised examinations and successful completion of prerequisite courses attend to the applicants' relative aptitude for academic success, based on the ability to understand, recall, and apply knowledge acquired in secondary education. A Canadian study of competencies required of registered nurses on entry to practice identified two abilities additional to those required for clinical and situational issues: interpersonal skills and problem-solving abilities (Manitoba Association of Registered Nurses, 1984, p. 98). The present study data illustrating a considerable proportion of

counselling and decision-making tasks supports the notion of these two abilities being community health nursing role related requirements. Aptitudes such as these, which are critical to competency development should therefore be included in the screening mechanisms used to select applicants.

ii). Predictors of Success for Competency Development

Identification and measurement of variables in addition to interpersonal skills and problem-solving abilities which would be predictive of success in achieving required nursing competencies would be important for the reduction of costs associated with student attrition and remediation, and for improving the relative efficiency of the future educational programme. Research is necessary for both development and evaluation of such variables.

iii). Allowance for Admission to Courses

Allowance must be made for mature age admission to the nursing courses. Competent demonstration of expertise must be requisites to acceleration. For many currently practising community health nurses, entry standards at the time of basic training were below senior matriculation level. Methods of competency-based testing must be devised for such

nurses seeking an educational basis from which to practise in community settings. These must be selected with an aim toward the standardisation of nomenclature and credentialling procedures, safety of client care, and allowances for the needs of the adult learner.

iv). Recruitment to Community Health Nursing Positions

Potential employers must adopt a hiring policy which reflects the importance of the role of primary care giver. The demographic data reveals a small minority of survey participants to be certified in community or public health. Efforts to upgrade to such a level must therefore be collaborative, with hiring policies including a learning contract toward primary health care certification, involving the committment of both employer and employee.

In addition, as suggested by Clark & Bozian (1983, p. 249), a growth period of socialisation to the community health nursing role should be provided during the orientation process. A system of competency-based experience could then be instituted as a correlate to academic competency toward improvement of the nurse's reality orientation. Orientation could follow the format of that in Victoria. Hurworth (1976, p. 82), relates that nurses in that state spend one month in

the practical situation, then attend a self and supervisor evaluated orientation course monthly. A forum for information exchange must be provided during orientation to allow communication between nurses at different experience levels and those working within different types of communities.

0.3.6.2 2. Amalgamation of Functional Categories of Nurses

The three functional categories of field, child health, and school health nurse should be replaced with one specialist community primary care nurse. The territorial boundaries of subspecialty groups of community health nurses are detrimental to efficient provision of community nursing care for today's health issues. Changes in health issues include increases in:

> "consumer cost, proportion of elderly in the population, chronic illness, cultural variation, technology and complexity of health care, the acuity of illness, health care provided in the community, mental health problems, multidisciplinary planning, the need for greater co-ordination of health services, and a demand for greater accessibility." (Canadian Nurses Association, 1982, p. 24).

As a result, the CHN is being forced to absorb a larger body of multidisciplinary knowledge than previously, to provide community health education, to provide for the

with a rapidly expanding role, and a comparatively longer expected work history than nurses have experienced in the past. The evidence from all studies points to an overwhelming need for more adequate preparation for the competencies required in practice. The logical approach is therefore, to derive a system of competency based education from systematic identification of task performance requirements.

Six research questions concerned with details of task performance were developed to guide the study. These are the following:

1. What are the competencies which comprise the role of the CHN upon which a curriculum should be based?

2. What is the relationship between the community health nurses' education, experience and task performance?

3. What is the extent of decision-making in the daily activities of the CHN in Western Australia?

4. Do existing educational curricula adequately prepare for required practice performance in community health nursing?

5. Could the survey instrument be used to

special needs of the aged, to understand stress related disorders and lifestyle contributors to wellness at different developmental stages, and to reassess personal lifestyles to serve as a role model in promoting health.

The volume of knowledge which must be assimilated demands a broader generalist base than that perpetuated by hospital-based programmes of nurse training. The current pre-registration curriculum with its multidisciplinary inputs and strong behavioural sciences components appears to provide the breadth required. Upon this base can be added specialty certificates to prepare groupings of nurses with demonstrable competence within defined areas of nursing practice. Benefits of such a system include preparation for life-long practice, increased flexibility, and enhanced portability of the credential.

0.3.6.3 3. Pre-Registration Curriculum

The scope and quality of the pre-registration curriculum should be correlated to practice needs to prepare for competency in the following areas:

i). The structure and function of political systems

from the community to the federal level, ergonomics, labour studies and how public health policies are made and influenced must be understood, for purposes of effective dialogue in non-medical environments.

ii). A working knowledge of information technology systems must be gained. This would include a degree of computer literacy to such a standard as to facilitate problem-solving for clerical and documentation activities.

iii). Family planning issues must be examined in depth in a sociocultural context to aid counselling activities.

iv). Sexuality related to development stages and life events must be understood and the appropriate communication skills mastered, toward improvements in counselling in this area.

v). Substance abuse and related psychosocial implications must be understood.

vi). Problem-solving techniques must be mastered.

vii). Teaching and learning principles must be explored to prepare for health education, health promotion, instruction and supervision of health workers, effective use of instructional media, public relations and motivational techniques.

viii). Cross-cultural issues in health care must be studied in detail to assist the CHN in the delivery of Aboriginal health care within its cultural context.

ix). Research methods, biostatistics, and epidemiology must be learned to such a level as to permit interdisciplinary research.

x). Public health, its historical influences, environmental effects of the present, and trends for the future must be appreciated, to aid in anticipation of health issues.

0.3.6.4 4. Accessibility of Nursing Programmes

Future basic programmes must include strategies for accessibility by utilising multiple settings and resources for learning. Difficulties in securing education were reported by nurses in isolated settings, as well as in Metropolitan Perth. Many of these had to do with the time constraints associated with both working and parenting. The following specific recommendations would enhance accessibility:

i). Implement educational programmes in different geographical locations. Distance education systems have been organised in W.A. because of accessibility

problems for other groups of learners. An example is the School of the Air, which offers isolated pre-primary to year 7 school students instruction in their own home. Such endeavours have necessitated coordination of such resources as the Education Department, T.A.F.E. institutions, The W.A.I.T. Media Services Unit, the Royal Flying Doctor Service, Telecom Australia, and the Western Australian Satellite Education Advisory Group. Accessibility could be improved if joint planning were undertaken between these resources and the School of Nursing at W.A.I.T.

ii). Coordinators of nursing education must be appointed in each region. These individuals would serve as a link between the School of Nursing, local education and health care institutions, and course participants in the region.

iii). A system of teleconferencing must be established which would enable two-way conversations between the student and regional coordinator, and between either of these and course leaders at W.A.I.T.

iv). Competency-based individualisation of study would demand that the educational programme reinforce and reward those students utilising self-directed study to develop clinical performance competencies. A flexible approach to both content and service delivery

is necessary. Educational counsellors should schedule tutorials at different times during the week (days, evenings, and weekends) and the year. Support services required include bursaries, loans, and scholarships, and government assisted leaves of absence. Collaboration with such employing agencies as the Health Department would aim at retaining job security for participants.

v). There must be national accreditation to facilitate transferability of learning modules. A conventionally understood method of communicating the standard of education completed must be implemented interstate and internationally.

0.3.6.5 5. Continuing Education

Mechanisms for improving delivery of continuing education programmes and providing for uniformity of content must be sought. The educational network established to provide pre-registration programmes could be used as a base from which to improve existing continuing education programmes, including the following:

i). A coordinator of continuing nursing education should receive a joint Health Department/Education

Department appointment. Such an individual would have access to community resources and the technological expertise to interact with resource personnel.

ii). Education coordinators in each region would conduct programme planning and development relevant to local needs.

iii). Incentives to continuing education must be provided. Of the ten paid conference days currently provided by the Health Department, half are spent during the annual inservice week. An equal number of days should be provided in the acute care setting, for purposes of updating knowledge and skills. Coordination of such a programme has already proven successful with the nurses attached to the R.F.D.S. base at Jandakot who, through an arrangement with Sir Charles Gairdner Hospital in Perth, receive yearly two week acute care updates, and participate in continuing education offerings at South Perth Community Hospital.

iv). Continuing education content should be expanded to include many currently non-registrable programmes. A system of awarding merits for seminars and short courses should be established. Examples of allowable local programmes include alcoholism training at Holyoake, the W.A. Institute on Alcohol and Addictions; family planning and sexuality training from the Family

Planning Institute; counselling and assertiveness training from the Centre for Advanced Studies at W.A.I.T., and sports injury management from the Physiotherapy Department at W.A.I.T. Self-directed learning modules, such as the School Nurse Achievement Program (Smith & Goodwin, 1982, pp. 535-538), should be registrable for those with the interest to pursue them. Individualised study assignments from such courses as family planning could be expanded to a level of acceptability as a one-half or one-third portion of a registrable social science unit.

v). Available community interdisciplinary offerings should be encouraged by such financial incentives as having course subscription and salary replacement costs subsidized by employers; by study time allowances, and by a system of 'banking' local continuing education programmes toward attendance at an international nursing conference. A similar system of banking preceptoring hours would provide for greater exchange of information between junior and experienced nurses.

vi). A system of information interchange must be established to link nurses within and between communities. Options for job sharing could be explored to promote greater intergroup understanding, and to aid in synthesizing what is learned, through peer interaction. An indirect benefit of such a scheme

would be enhancement of formative evaluations by seminar-type learning, in that "discussion and analysis of experience promotes vicarious learning between nurses" (Archer, 1982, p. 445).

0.3.6.6 6. Further Research

i). The instrument to assess task performance should be evaluated with a different group of participants who have received instruction in its method.

ii). Entry aptitudes should be studied with a view toward compiling a list of possible predictors of success in community health nursing.

iii). Studies assessing problem-solving ability should be conducted.

iv). Efficacy of the roles of community health nurses must be systematically evaluated in terms of client outcomes, to answer the question: Does the school health nurse increase school health, the child health nurse increase child health, the field nurse increase health in the community at large?

v). Studies addressing job satisfaction and client care outcomes should be conducted to answer the question: Does a satisfied nurse practice more

competently than a dissatisfied nurse?

vi). A study should be designed to answer the questions: When nurses have higher education, have they gained community evaluative skills? Do nurses with more assessment skills spend more time with the client at each visit? Do the fastest nurses have the longest list of tasks? Do similarly trained nurses vary in their perceptions of the same task requirements?

viii). A study should investigate whether the socialisation which occurs from hospital-based training is an impediment to flexible curriculum development, and whether it inhibits multidisciplinary collaboration.

0.3.7 A Further Objective

An initial objective listed in chapter one predicted that participation in the study would raise the self-consciousness of the CHN in regard to individual professional activities, with the aim of improving his or her documentation. It is apparent from the profusion of respondents' comments on time pressures, job stress, and the survey burden, that this objective has not been achieved. Several nurses supported the survey objectives; commented on as: "We must speak up for ourselves and support those who are doing it for us." Others related that they are so busy that it is difficult to consider research participation as a high priority activity. Awareness of professional activities and the need for further education is apparent among the majority of this group of community health nurses. Health Department nurses attending the annual inservice conference produced a prolific list of desired inservice programmes, as they did the previous year, and which formed the basis for this year's programmes. Many of the needs listed were duplications of learning needs identified in the study.

Ideally, a survey such as the present one would leave the participant contemplating task performance in the context of the work environment, questioning and

documenting components, methods and rationales. Description of practice activities for this group is however, circumvented by the time constraints which diminish the incentive to devote sufficient time to documenting performance. Additionally, there still exist purveyors of the traditional system of nursing education, who offered several anti-intellectual comments on the "academic-type nurse" as lacking the real world orientation gained from the discipline and structure of hospital-based nursing programmes. These respondents may be vocalising the sense of 'frustrated entitlement' referred to in chapter two (Bullough, Bullough, & Soukup, 1982), which is a result of the pressure to conform to rapidly changing educational standards, and feeling that a lifetime's work is being either minimised or discredited. Care must therefore be taken, to proceed with curriculum change cautiously, and with the cooperative efforts of both practitioners and programme planners.

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CHAPTER FIVE

SUMMARY, FINDINGS AND DISCUSSION

0.1 SUMMARY

The purpose of the present study has been to investigate the task performance requirements of the community health nurse in Western Australia, and subsequent implications for curriculum development. The study is set within the context of recent literature describing historical developments pertinent to nursing education in Australia; education needs related to the current and projected future role of the CHN, and comparative systems of educational preparation for community health nursing.

There is support in the literature for the contention that nursing education in Australia is in a period of dynamic evolution, resulting in the need for precision in educational programme planning. Comparative studies reflect a wide range of choices in the educational preparation of

the community health nurse for the role of primary care giver. In some locations, there has been a polarization of views on the issue of all-tertiary vs hospital-based education for nurses. Resolution of the conflict has been evident in the choices made in New Zealand and, most recently, in Australia, to pursue all-tertiary level nurse education. North American and British nurses have struck the compromise of coexistent hospital-based and tertiary-based programmes.

Studies addressing role-related requirements present the convergent view that the CHN role requires a broad, generalist orientation to health care delivery, with community health specialisation added to this. Studies on specific issues in curriculum development present the alternatives of educating the undergraduate nurse as a generalist, and adding a specialty curriculum for community health certification, or preparing a specialist undergraduate. Many curriculum studies reflect the need for individualised learning mechanisms and external studies options to overcome the difficulties of inaccessibility to nursing programmes, and to permit articulation to higher levels of nursing. Others focus on the continuing education needs of the CHN to keep up

identify task performance requirements of other groups of nurses?

6. What recommendations arising from the data can be made regarding recruitment and educational programme planning for community health nursing?

An instrument to assess task performance was designed in the format of a survey questionnaire to be completed on three separate occasions, by community health nurses practising within the Health Department of W.A. Task list items were evaluated by a panel of 13 experienced nurses and nurse educators. Following refinement of the list, the questionnaire was assembled in such a way as to elicit information from participants on the quantity and type of tasks performed, the source of initiation of individual tasks; the source of preparation, and degree of preparedness perceived for task performance.

Open ended questions asked each respondent to identify needs for continuing education and those which would have enhanced previous education, then invited comment on any topic relevant to the study.

The survey was pilot tested, then mailed to 364 community health nurses throughout the state.

Simultaneously, personal interviews were conducted with community health nurses in one of the five regions of the state, in an attempt to observe and clarify the role of the community health nurse in context. The preliminary analysis of data involved the study of responses to all items of the questionnaire, and the interview data. These findings will be presented in the section to follow.

0.2 FINDINGS

The number of usable responses to the questionnaire was 96, with a further 48 nurses responding to the follow-up notice which offered the option of describing a 'typical day' and identifying educational needs, instead of completing the detailed questionnaire. The two groups of respondents combined, resulted in 144 replies to the questions relating to educational needs, and open-ended comment.

Data from the 96 original respondents was analysed to relate education, experience and functional category to task performance. The average number of daily tasks performed was 245.71, distributed over the ten task categories. When the numbers of individual tasks were averaged over the three survey days, for nurses in all functional, education, and experience groups, documentation tasks were reportedly performed most frequently, followed by history taking, teaching, direct care-giving, deciding priorities, counselling, resources identification, follow-up and review activities, outcome evaluation, and

coordination and liaison tasks.

Analysis of variance for individual tasks revealed several significant differences. Rural nurses performed fewer numbers and percentages of documentation tasks, and higher percentages of deciding priorities tasks. This was a predictable finding in that the rural nurse deals with a smaller community of clients, and the implications of minimising or delaying documentation tasks are less profound than in the urban environment, where the larger client case load, and involvement of more health care personnel requiring access to client information necessitates keeping documentation current. Similarly, less intergroup collaborative health care than the urban nurse experiences may be the reason for a higher percentage of deciding priorities tasks left to the rural nurse. In the rural areas, the implications of such planning activities as deciding priorities, are somewhat more important in view of the time and distances often required, for both the nurse making a trip to the client's environment, or the client making a trip to see the nurse. An additional finding, that of a significantly higher percentage of coordination and liaison tasks for field nurses, could be

attributed to the same reason. Arrangements must be confirmed and organised to the last detail, when travel to the home is required, whereas the mobile urban client can often be channeled to a number of alternative resources if prescribed plans present obstacles to receiving care.

Three significant findings related to school health nurses. As he or she performs the majority of screening assessments, a higher number and percentage of history taking tasks for this group presented a predictable finding. In addition, the higher percentage of direct care giving by this group could be attributed to the acute care and first aid demands of the high school health nurse's role, with follow-up often being attended to by sources (parents, family physician) other than the school based health centre.

A large proportion (83.00%) of tasks performed were reportedly self-initiated. Significant differences in source of initiation included a higher percentage of self-initiated tasks for urban nurses, and a higher number and percentage of supervisor-initiated tasks for rural nurses. As staff turnover is highest among rural nurses, it may be that rural nurses having only recently assumed their position, would report a higher

number of supervisor-initiated tasks. Field nurses reported a significantly higher percentage of other-initiated tasks, presumably, because their home visits are often requested by family members, or others working with the client. Discretion in interpreting these findings is necessary in view of the relatively low proportion of both supervisor and other-initiated tasks.

When source of preparation items were analysed, several significant findings were revealed. Post-diploma course was identified most frequently by the two higher education groups, and child health nurses, who hold the largest number of post-diploma certificates. Books and articles was identified most frequently by those in the highest education category, (those who have had greater exposure to books and articles than others), and by outpost and rural nurses, who receive regular mailing of articles from the Health Department library in an attempt to keep them updated on current topics. School health nurses reported this source of preparation less frequently than other groups.

Inservice was identified a significantly greater number of times by child health nurses. This finding is unsurprising in view of the fact that

this group receives the greatest number of inservice presentations. An interesting finding was that the higher education groups identified experience as a source of preparation a significantly greater number of times than did others, including those in the higher experience groups. Experience was the most frequently identified source of preparation by all respondents.

Of all ratings of degree of preparation for task performance, 92.75% of respondents' ratings were allocated as 'none' or 'a few problems'.

There were 193 responses identifying needs for continuing education. Only minor differences were seen in functional, education and experience groups, when needs were ordered according to the ten most frequently identified. The rank order of needs identified by all groups was as follows: counselling and related human relations skills, current medical conditions, coping and stress management, practise in community and clinical nursing, teaching techniques, information sharing with other nurses, community liaison skills, time off to attend courses, role-related topics, nursing studies-theory, research methods, and the need for interdisciplinary education.

Subject areas which would have enhanced previous education were identified by 188 respondents. The frequency distribution for education, experience and functional groups was relatively constant, with the ten most frequently occurring items showing marked similarities to the identified needs for continuing education. Open ended comments and the information gleaned during the interviews completed the data.

Interpretation of the findings in the context of answering the six research questions included derivation of a list of competencies for community health nursing. It was learned that competencies in all ten task areas, in decision-making and organisational ability are necessary prerequisites to role performance. Additionally, the relationship between education, experience and task performance was found to be subsumed by contextual factors, which have a more profound impact as the determinant of task performance.

The definition of primary care nurse as decision-maker was supported, with nurses in all functional, education, and experience categories engaged in deciding priorities tasks.

The curricula for both pre-registration

(W.A.I.T.), and continuing education (Health Department) were evaluated in terms of the competencies required of the CHN. Both curricula appear to be adequate in a majority of substantive areas, with some exceptions. The areas of family planning, sexuality, substance abuse, Aboriginal culture, group leadership skills, and health worker training were identified as specific areas for further development. In addition, it is considered that educational preparation in such interdisciplinary areas as information systems technology, and community political systems would enhance current curricula. The importance of the continuing education curriculum was revealed by the relatively high frequency with which inservice was identified as a source of preparation for task performance. The most important improvements would be in service delivery, improving accessibility to both curricula, and presenting a more consistent, uniform distribution of continuing education components throughout the regions.

The survey instrument was evaluated for its present and future usefulness. It was determined that few nurses conceptualised their practice according to the nursing process steps of

assessment, planning, implementation and evaluation. A difficulty encountered by respondents was in apportioning nursing care into discrete tasks. The most useful improvement to the survey instrument, would be in personally introducing it to potential respondents to promote consistency of task allocation. In addition, the amount of detail expected of survey participants presented a relatively large response burden, therefore, a shortened version would possibly serve to improve the response rate.

the complex role of the nurse in the community. As the list of competencies derived from the questionnaire data suggests, the CHN is a diagnostician of individual and aggregate; a manager-coordinator; a problem-solver; a communicator; a researcher; a coper; and an innovator. These interrelated roles provide the means to exert influence on the client/consumer, the health care system, and the profession. Against the background of societal changes in technology, economics, culture, attitudes, and demographics, the CHN of today is in a position, as Gibbon (1983, p. 53) suggests, to influence governments for the improvement of health care; to effect changes in geriatric and long term care, shifting emphasis from illness to personhood; to adequately relate to the sophisticated consumer; and to promote the judicious use of technology in areas such as palliative care. The nurse of the future will therefore require "greater competence in health assessment, communications techniques (teaching, counselling and stress management) and critical thinking skills." (Manitoba Association of Registered Nurses, 1984, p. 7).

The profession must promote the idea that the role of generalist primary care nurse is an

attractive alternative to field nurse, child health nurse or school health nurse. The CHN must be a generalist, setting aside the community-based specialist boundaries and their cognate status and security, to provide for the "comprehensive and generalised packages of needs and expectations of clients." (Archer, 1977, p. 114). The specialisation of the past may prove to have been a limiting factor in the underutilisation of community health nurses. This remains to be learned by effective intra and intergroup dialogue. Collegial exchange of information could have far reaching results. For example, as the data base for a continuum of decisions is compiled by the nurse, participative problem-solving for efficient documentation techniques would be a useful innovation. Multidisciplinary exchanges may prove just as beneficial for mutual administrative, managerial, and educational development. Reciprocal support systems for coping and stress management would present an additional benefit. With the added complexities of the community health nursing role, higher levels of work-related stress have become apparent. Survey respondents described an overwhelming amount of role-related stress. Detrimental effects include those to the

consumer. Janis (1982, p. 148) reflects:

> "Stress itself is frequently a major cause of errors in decision-making. This assumption does not deny the influence of other common causes, such as information-processing, group pressures, blinding prejudices, ignorance, organizational constraints and bureaucratic politics."

Evolution of the role has therefore resulted in both gains and compromises. Gains to the consumer include the wider scope of community-based health care. Gains to the profession have included the intellectual stimulation and sustained interest which accompanies a dynamic work environment. Compromises to the consumer have included some dissemination of services over a large number of health care personnel. Compromises to the profession include a diminished sense of professional security, and some loss of cohesion in the face of ill-defined role limitations. Resolution of the compromises must be approached through remedial and continuing education. The contention is therefore, that the key to meeting the needs of both consumer and care giver lies in the organisational template for educational preparation for community health nursing practice requirements.

0.3.2 Curricula for Community Health Nursing Practice

It is suggested that a discrepancy exists between the competencies required of the CHN and curriculum development to prepare for those competencies. The W.A.I.T. pre-service nursing course and bridging course for articulation from diploma to baccalaureate level provides an example of systematically planned, performance-based curricula, which, in future, may reduce the discrepancy. Evaluation of graduates of this programme has been pursued by such Western Australian researchers as Lonsdale (1982) on a somewhat smaller scale than the larger evaluative studies of tertiary level graduates in Victoria (McArthur, Brooke, & Bruni, 1981).

The majority of feedback regarding graduates of the W.A.I.T. programmes has come from course evaluations and conjectural reports from nurses in community settings who serve as preceptors for the students during experiential components. It remains for future evaluations to determine if such comprehensive tertiary level preparation translates to role and practice changes, and improved client care outcomes.

Evidence from the present study, and those of Carr (1978), and Munoz and Mann (1982), suggests that practising community health nurses rely heavily on experience for expertise. Trial and error methods of selecting care-giving tactics inhibit the development of quality assurance standards of competency which regulate consistent, safe care, and operationally, elevate the status of the profession. This trend could be reversed with the institution of an organisation to address all aspects of educational quality assurance for the practising CHN. Systematic application of a continuing education programme encompassing distance education networks must be carried out from a critically evaluated delivery system. This includes forward planning to such an extent that course certification would be approved before courses were conducted, by a joint committee with representation from education and health care interests. Prior to such courses being offered, evaluation of course content and delivery mechanisms employed in other states and other countries must be explored, to avoid duplication of effort. Such learning materials as the Model for Guided Study to assist the independent learner (Hicks, Price, Swartz, & Thurn, 1983), and the Community Cultural Assessment Tool (Gagnon, 1983),

can be 'borrowed' from those who have utilised them successfully. Implementation of other successful programmes would eliminate content trials and exploratory programmes which can only be considered cost effective when an idea or programme has had no precedents.

As quality assurance standards in nursing are similar interstate and internationally, legislating compulsory minimum continuing education requirements would aid in improving professional mobility, and may facilitate securing government funding. The obstacles to accessibility must then be overcome by the organisation of delivery. Initially, trained personnel must be secured. A workable plan would include rigorous substantive assessment of learning needs. Information technology, counselling techniques, cross-cultural studies, family planning and sex education, substance abuse, teaching and public relations techniques, and effective utilisation of public health and political systems, have been among the content areas suggested thus far. Certification of these and other areas must be brought to a standard of applicability to the Bachelor of Applied Science (Nursing) component units.

As Congalton (1977, p. 194) cautions from the British experience with innovative curricula, the nurses and everyone concerned must be informed of reasons for change and the nature of changes to the curricula, to enable a smooth transition to the new structure. This step is also advanced by Arth, Lounsbury & Baribeau (1978, p. 295) as one of three guidelines to curriculum change in any educational setting. These authors state that care must be taken not to set in motion defensive, self-survival reactions which prevent open consideration of curriculum changes; that a 'place' for all individuals involved must be created, and that options, indications of support, and a full elaboration of implications should be provided.

Resources identification must be done to match existing resources to identified needs, and for planning of future contractual arrangements. A system of incentives, both financial and professional, should be offered to encourage participation. Reassurance of job security must be given to those requiring leaves of absences to complete coursework. Tutors and resource personnel must be available in each region to eliminate further travel burdens to course

participants. A system of preceptorship must be established as an interactive teacher/learner forum and as a vehicle from which to promote the cross-fertilisation of ideas. The key to successful curriculum development may be in the joint appointment to education and health care institution. New approaches must be cooperative in order to effect a correlated curriculum and to guard against improvident perpetuation of existing educational standards in community health nursing.

0.3.3 Research Foundation for Curriculum Development

The goal of nursing education, according to Ptak (1978, p. 118), ought to be the accountability of the educational programme to the consumer (student, University, society at large). She contends that the role of evaluation is to find relationships between variables which improve the educational process. Acknowledging the fact that measurement difficulties have traditionally been a deterrent to clinical evaluation studies in nursing, the Encyclopedia of Educational Research commentary on nursing education (1982, p. 1358),

stresses the importance of persevering in such evaluation. One solution to overcome these difficulties is to engage in collaborative evaluation between practitioners and those with expertise in the measurement and analytic sciences. According to Mechanic (1979, p. 133), "Evaluations that are...organised in close cooperation with those who execute programs...have more potential." Research incentive programmes could include registrable credits for practice-based research projects. Regular reviews and monitoring procedures built into the organisational structure of educational programmes could provide the basis for ongoing research activities.

The need for a study of factors affecting task performance was first proposed by Archer (1977, p. 124), and reiterated by Orem (1980, p. 25):

> "Task performance is a constituent of all practice endeavours, and nurses must be skilled in task analysis, in task synthesis to form valid courses of action, and in task performance. Nurses should understand how tasks, including task sequences, fit into the larger designs for self-care and nursing, and understand how to select and perform those tasks."

In describing task performance, the present study has provided a step in this direction, but

represents only the tip of the iceberg. The need remains for formative evaluation for curriculum development. One exemplary area is that which would evaluate audio-visual technology. Not enough studies have been conducted, according to Green (1977, p. 157-158) to determine if today's technology is as instructionally effective as it is slick. A question is raised as to whether the decrease in training time in utilising computer assisted instructional systems can be translated into cost savings to the system. Many researchable questions remain unanswered: What are the client outcomes of task performance? Can a measurement instrument be devised for problem-solving and counselling abilities? There is also a need for summative evaluation to enable administrators to decide if the finished product, the curriculum, refined by formative evaluation, represents a significant advance on previous curricula. Performance-based research activities must therefore be stimulated and encouraged by professional nurturance.

0.4 SUMMARY

Widespread changes are occurring in nursing education in Australia at the present time. In the past, the nurse in the community setting has been relegated to following the lead of acute care contemporaries for educational programme development. The global movement to community-based health care is now providing an opportune forum for the germination of ideas from the nurses who have been in the community all along. Their ideas must be tapped, and others' stimulated. It is critical that community health nurses instigate research activities as the basis for programme planning As urged by Professor McFarlane in her recent plea to generate a universal body of nursing research: "The difference between obsolesence and excellence is inertia." (1984).

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Dear Colleague,

This study, with the support and permission of the Department of Community Nursing, is an attempt to conduct research into the functions and task requirements of the Community Nurse in Western Australia. I intend the study to form the basis of a thesis on Community Health Nursing toward a Master's degree in Education at the University of Western Australia. Therefore, although your co-operation is not mandatory, it would be much appreciated. In addition, I hope that the findings will contribute to our knowledge within the field of Community Health Nursing and elevate the profile of the Community Health Nurse in all work environments.

INSTRUCTIONS

You will receive survey forms and a stamped self-addressed envelope. the envelopes are addressed to Joan Bedford in the Statistics Branch of the Public Health Department (for my convenience), but I will be collecting them as they are received by the Statistics Branch. Please complete each form on the day indicated at the top, (or your next working day), then mail the forms to me as soon as possible after completing them.

You will be asked to provide information on your education and experience, and the tasks which you were required to perform on the date indicated. Even though your nursing process is considered to be 'client-oriented' rather than 'task-oriented', it is assumed that within each client, family, group or community contact, multiple tasks may be required.

1. Please indicate in the appropriate column the number of tasks you performed today which were initiated by: M = Me alone or in collaboration with others; S = Supervisor; C = Client; O = Other (family member, teacher, social worker, physician, etc.).

2. Rate what you consider the 'Degree of preparation', and

3. 'Source of Preparation' for performing the tasks (as illustrated on the next page).

You may then have some suggestions for your present and continuing educational requirements and some thoughts on what would have improved your earlier education. In addition, you may remember any past events of note (either simple events or something as complex as medical assistance at a flood or bush fire) for which you could offer comment on how prepared you felt for the tasks you were required to perform, and the source of that preparedness, or any other topics you wish to comment on. Please feel free to do so on page 5.

Finally, I would then like to invite you to telephone me if you wish to discuss any part of the study or if you have difficulty completing the form.

Thank you in advance for your co-operation.

Anne McMurray,
Kingswood College,
Hampden Road,
CRAWLEY, W.A., 6009.

Telephone : (09) 389 1129.

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Appendix A 11)

PART TWO PLEASE COMPLETE ON ..... (OFFICE USE ONLY)

QUESTIONNAIRE NUMBER	[1] [2] [3]	4

ASSESSMENT

1. HISTORY TAKING

(screening, problem identification for: Client, Family Members, Group or Community)

NUMBER & ORIGIN:	ME	[ ][ ]	35, 36
	SUPERVISOR	[ ][ ]	37, 38
	CLIENT	[ ][ ]	39, 40
	OTHER	[ ][ ]	41, 42
DEGREE OR PREPARATION:	NO EXPERTISE	[1]	43
	ALMOST NO EXPERTISE	[2]	
	MANY PROBLEMS	[3]	
	ONE OR A FEW PROBLEMS	[4]	
	NO PROBLEM AT ALL	[5]	
SOURCE OF PREPARATION: (tick as many as apply)	BASIC NURSING TRAINING	[1]	44
	POST DIPLOMA COURSE	[2]	45
	IN-SERVICE	[3]	46
	SUPERVISOR	[4]	47
	CO-WORKERS	[5]	48
	BOOKS, ARTICLES	[6]	49
	PAST EXPERIENCE	[7]	50
	EXPLANATION BY CLIENT	[8]	51

2. RESOURCES IDENTIFICATION

(Potential help from: Client, Family Members, Group or Community)

NUMBER & ORIGIN:	ME	[ ][ ]	52, 53
	SUPERVISOR	[ ][ ]	54, 55
	CLIENT	[ ][ ]	56, 57
	OTHER	[ ][ ]	58, 59
DEGREE OR PREPARATION:	NO EXPERTISE	[1]	60
	ALMOST NO EXPERTISE	[2]	
	MANY PROBLEMS	[3]	
	ONE OR A FEW PROBLEMS	[4]	
	NO PROBLEM AT ALL	[5]	
SOURCE OF PREPARATION: (tick as many as apply)	BASIC NURSING TRAINING	[1]	61
	POST DIPLOMA COURSE	[2]	62
	IN-SERVICE	[3]	63
	SUPERVISOR	[4]	64
	CO-WORKERS	[5]	65
	BOOKS, ARTICLES	[6]	66
	PAST EXPERIENCE	[7]	67
	EXPLANATION BY CLIENT	[8]	68

3. DECIDE PRIORITIES FOR:

Intervention to be taken, time & resources management, programme planning & evaluation, evaluation method & timing.

Duplicate Cols. 1-4

NUMBER & ORIGIN:	ME	[ ][ ]	5, 6
	SUPERVISOR	[ ][ ]	7, 8
	CLIENT	[ ][ ]	9, 10
	OTHER	[ ][ ]	11, 12
DEGREE OR PREPARATION:	NO EXPERTISE	[1]	13
	ALMOST NO EXPERTISE	[2]	
	MANY PROBLEMS	[3]	
	ONE OR A FEW PROBLEMS	[4]	
	NO PROBLEM AT ALL	[5]	
SOURCE OF PREPARATION: (tick as many as apply)	BASIC NURSING TRAINING	[1]	14
	POST DIPLOMA COURSE	[2]	15
	IN-SERVICE	[3]	16
	SUPERVISOR	[4]	17
	CO-WORKERS	[5]	18
	BOOKS, ARTICLES	[6]	19
	PAST EXPERIENCE	[7]	20
	EXPLANATION BY CLIENT	[8]	21

IMPLEMENTATION

4. DIRECT CARE GIVING

(To Client, Family, Group or Community)

NUMBER & ORIGIN:	ME	[ ][ ]	22, 23
	SUPERVISOR	[ ][ ]	24, 25
	CLIENT	[ ][ ]	26, 27
	OTHER	[ ][ ]	28, 29
DEGREE OR PREPARATION:	NO EXPERTISE	[1]	30
	ALMOST NO EXPERTISE	[2]	
	MANY PROBLEMS	[3]	
	ONE OR A FEW PROBLEMS	[4]	
	NO PROBLEM AT ALL	[5]	
SOURCE OF PREPARATION: (tick as many as apply)	BASIC NURSING TRAINING	[1]	31
	POST DIPLOMA COURSE	[2]	32
	IN-SERVICE	[3]	33
	SUPERVISOR	[4]	34
	CO-WORKERS	[5]	35
	BOOKS, ARTICLES	[6]	36
	PAST EXPERIENCE	[7]	37
	EXPLANATION BY CLIENT	[8]	38

5. TEACHING:

(Client, Family Group or Community)

NUMBER & ORIGIN:	ME	[ ][ ]	39, 40
	SUPERVISOR	[ ][ ]	41, 42
	CLIENT	[ ][ ]	43, 44
	OTHER	[ ][ ]	45, 46
DEGREE OR PREPARATION:	NO EXPERTISE	[1]	47
	ALMOST NO EXPERTISE	[2]	
	MANY PROBLEMS	[3]	
	ONE OR A FEW PROBLEMS	[4]	
	NO PROBLEM AT ALL	[5]	

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PART THREE Appendix A iii)

Please comment on:

1. YOUR NEEDS:

   A. What would you like to see provided in continuing education or inservice?

   B. What do you wish had been provided at what part of your training? (pre and post-basic).

2. OTHER COMMENTS:

FINAL INSTRUCTION

Please mail the survey forms to me as soon as possible. Personal information will be kept confidential, and I will inform you of any study findings when all the information is compiled. Thank you, once again.

Anne McMurray.

Appendix B: Letter of Permission for Study

PUBLIC HEALTH DEPARTMENT
60 BEAUFORT STREET PERTH
WESTERN AUSTRALIA
TELEPHONE 328041
TELEX [illegible]
TELEGRAMS WAHEALTH
LETTERS BOX 8172 STIRLING STREET
G.P.O. PERTH 6001

Your Ref
Our Ref EDP:IDM
Enquiries

Miss A McMurray
Kingswood College
Hampden Road
CRAWLEY 6009

Dear Miss McMurray

Thank you for your letter requesting permission to conduct a research study into the task performance requirements of Community Health.

I have discussed your proposal with Mrs Baskin and I am happy to give my approval.

Following the conclusion of your study we would appreciate a report on your findings as suggested in your letter and also comments on how you see your findings being applied to a nursing service such as ours could be of value.

We wish you well with your studies and trust your research programme will furnish you with valuable information that can be used for the benefit of nurses not only here in W.A. but with a much wider application.

Yours sincerely

J C McNulty
COMMISSIONER OF PUBLIC HEALTH

May 30, 1984.

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APPENDIX C

The Panel of Experts to Assess the Task List

Community Health Nursing Administrators

Mrs. Pat Baskin - Deputy Acting Principal Director, Communi Nurses Division, Department of Health.

Miss Noreen Chidlow - Director, Community Nursing, Metropolit Perth, & State Advisor for Child Health.

Nurses Board Education Officer

Mrs. Pauline Lambert, Principal Nursing Education Officer.

Community Health Research Officer

Miss Joan Bedford, Research Officer, Community & Child Healt Services, Department of Health.

Nurse Educators

Miss Robin Watts, Head of School of Nursing, W.A.I.T.

Mrs. Audrey Martins, Lecturer, School of Nursing, W.A.I.T.

Ms. Dorothy Watkins, Nurse Educator for Community Healt Nursing, W.A.S.O.N.

Senior Nurses, Community & Child Health Services

Mrs. Margaret Bayley, Sr. Nurse, Child Health, Metropolita Perth.

Ms. Maureen Helen, Sr. Nurse, School Health, Metropolita Perth.

Mrs. Laurette Keddie, State Advisor, School Health, Director Community Nursing, S.W. Region.

Mrs. Betty Lowrie, Deputy Director, Community Nursing.

Mrs. Pat. Campbell, Deputy Director, Community Nursing.

Regional Supervisor

Mrs. Hazel Brandreth, Regional Supervisor, Community Nursing N. Metropolitan Perth.

Appendix E: Letter of Introduction to Pilot Study Group

Dear Colleague;

This study, with the support and permission of the Dept. of Community Nursing, is an attempt to conduct research into the functions and task requirements of the Community Nurse in Western Australia. I intend the study to form the basis of a thesis on Community Health Nursing toward a Master's degree in Education at the University of Western Australia. Therefore, although your co-operation is not mandatory, it would be much appreciated. In addition, I hope that the findings will contribute to our knowledge within the field of Community Health Nursing and elevate the profile of the Community Health Nurse in all work environments. You have been nominated by your Senior Nurse as one of twelve participants to pilot test the study. Therefore, I would much appreciate your comments on any aspect of the study as well as your participation.

INSTRUCTIONS You will receive a survey form and a stamped self-addressed envelope. Please complete the form on the day shown at the top of the form, (or your next working day), then mail the form to me as soon as possible after completing it.

You will be asked to provide information on your education and experience, and the tasks which you were required to perform on the date indicated. Even though your nursing process is considered to be 'client-oriented' rather than 'task-oriented', it is assumed that within each client, family, group or community contact, multiple tasks may be required.

1. Please indicate in the appropriate column the number of tasks you performed today which were initiated by: M. = Me - alone or in collaboration with others; S = Supervisor; C = Client; O = Other (family member, teacher, social worker, physician etc.) 2. Rate what you consider the 'Degree of preparation', and 3. 'Source of Preparation' for performing the tasks (as illustrated on the next page).

You may then have some suggestions for your present and continuing educational requirements and some thoughts on what would have improved your earlier education. In addition, you may remember any past events of note (either simple events or something as complex as medical assistance at a flood or bush fire) for which you could offer comment on how prepared you felt for the tasks you were required to perform, and the source of that preparedness, or any other topics you wish to comment on. Please feel free to do so on page 4.

Finally, I would then like to invite you to telephone me if you wish to discuss any part of the study or if you have difficulty completing the form.

BEST COPY AVAILABLE

Inter-Library Loan
Kingswood College
09 341 1129

Dear Colleague

I'm still hoping to receive survey forms from you, describing your activities on three work days. Perhaps you are about to return these - complete or incomplete. I'd appreciate receiving them, even if they're not complete.

If the form was too detailed to be completed at the end of a busy day, there is an alternative possibility. Remember that getting a clear picture of your actual workload is crucial for providing recommendations for inservice which will be useful for you, and improving professional training for future nurses.

THE ALTERNATIVE SUGGESTION IS THIS: USE YOUR OWN WORDS TO DESCRIBE WHAT YOU DID ON ONE TYPICAL WORK DAY (ANY DAY IN THE NEXT SEVEN).

A form is attached for your convenience, but use notepaper if you prefer. Please mail these forms in the envelope provided.

Once again, thank you for your cooperation.

Anne McMurray

Anne McMurray
Kingswood College
Hampden Road
CRAWLEY WA 6009

Appendix A 11)

PART TWO PLEASE COMPLETE ON ..... (OFFICE USE ONLY)

QUESTIONNAIRE NUMBER	[1] [2] [3]	4

ASSESSMENT

1. HISTORY TAKING

(screening, problem identification for: Client, Family Members, Group or Community)

NUMBER & ORIGIN:	ME	[ ][ ]	35, 36
	SUPERVISOR	[ ][ ]	37, 38
	CLIENT	[ ][ ]	39, 40
	OTHER	[ ][ ]	41, 42
DEGREE OR PREPARATION:	NO EXPERTISE	[1]	43
	ALMOST NO EXPERTISE	[2]	
	MANY PROBLEMS	[3]	
	ONE OR A FEW PROBLEMS	[4]	
	NO PROBLEM AT ALL	[5]	
SOURCE OF PREPARATION: (tick as many as apply)	BASIC NURSING TRAINING	[1]	44
	POST DIPLOMA COURSE	[2]	45
	IN-SERVICE	[3]	46
	SUPERVISOR	[4]	47
	CO-WORKERS	[5]	48
	BOOKS, ARTICLES	[6]	49
	PAST EXPERIENCE	[7]	50
	EXPLANATION BY CLIENT	[8]	51

2. RESOURCES IDENTIFICATION

(Potential help from: Client, Family Members, Group or Community)

NUMBER & ORIGIN:	ME	[ ][ ]	52, 53
	SUPERVISOR	[ ][ ]	54, 55
	CLIENT	[ ][ ]	56, 57
	OTHER	[ ][ ]	58, 59
DEGREE OR PREPARATION:	NO EXPERTISE	[1]	60
	ALMOST NO EXPERTISE	[2]	
	MANY PROBLEMS	[3]	
	ONE OR A FEW PROBLEMS	[4]	
	NO PROBLEM AT ALL	[5]	
SOURCE OF PREPARATION: (tick as many as apply)	BASIC NURSING TRAINING	[1]	61
	POST DIPLOMA COURSE	[2]	62
	IN-SERVICE	[3]	63
	SUPERVISOR	[4]	64
	CO-WORKERS	[5]	65
	BOOKS, ARTICLES	[6]	66
	PAST EXPERIENCE	[7]	67
	EXPLANATION BY CLIENT	[8]	68

3. DECIDE PRIORITIES FOR:

Intervention to be taken, time & resources management, programme planning & evaluation, evaluation method & timing.

			Duplicate Cols. 1-4
NUMBER & ORIGIN:	ME	[ ][ ]	5, 6
	SUPERVISOR	[ ][ ]	7, 8
	CLIENT	[ ][ ]	9, 10
	OTHER	[ ][ ]	11, 12
DEGREE OR PREPARATION:	NO EXPERTISE	[1]	13
	ALMOST NO EXPERTISE	[2]	
	MANY PROBLEMS	[3]	
	ONE OR A FEW PROBLEMS	[4]	
	NO PROBLEM AT ALL	[5]	
SOURCE OF PREPARATION: (tick as many as apply)	BASIC NURSING TRAINING	[1]	14
	POST DIPLOMA COURSE	[2]	15
	IN-SERVICE	[3]	16
	SUPERVISOR	[4]	17
	CO-WORKERS	[5]	18
	BOOKS, ARTICLES	[6]	19
	PAST EXPERIENCE	[7]	20
	EXPLANATION BY CLIENT	[8]	21

IMPLEMENTATION

4. DIRECT CARE GIVING

(To Client, Family, Group or Community)

NUMBER & ORIGIN:	ME	[ ][ ]	22, 23
	SUPERVISOR	[ ][ ]	24, 25
	CLIENT	[ ][ ]	26, 27
	OTHER	[ ][ ]	28, 29
DEGREE OR PREPARATION:	NO EXPERTISE	[1]	30
	ALMOST NO EXPERTISE	[2]	
	MANY PROBLEMS	[3]	
	ONE OR A FEW PROBLEMS	[4]	
	NO PROBLEM AT ALL	[5]	
SOURCE OF PREPARATION: (tick as many as apply)	BASIC NURSING TRAINING	[1]	31
	POST DIPLOMA COURSE	[2]	32
	IN-SERVICE	[3]	33
	SUPERVISOR	[4]	34
	CO-WORKERS	[5]	35
	BOOKS, ARTICLES	[6]	36
	PAST EXPERIENCE	[7]	37
	EXPLANATION BY CLIENT	[8]	38

5. TEACHING:

(Client, Family Group or Community)

NUMBER & ORIGIN:	ME	[ ][ ]	39, 40
	SUPERVISOR	[ ][ ]	41, 42
	CLIENT	[ ][ ]	43, 44
	OTHER	[ ][ ]	45, 46
DEGREE OR PREPARATION:	NO EXPERTISE	[1]	47
	ALMOST NO EXPERTISE	[2]	
	MANY PROBLEMS	[3]	
	ONE OR A FEW PROBLEMS	[4]	
	NO PROBLEM AT ALL	[5]	

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SOURCE OF PREPARATION: (tick as many as apply)	BASIC NURSING TRAINING	[1]	48
	POST DIPLOMA COURSE	[2]	49
	IN-SERVICE	[3]	50
	SUPERVISOR	[4]	51
	CO-WORKERS	[5]	52
	BOOKS, ARTICLES	[6]	53
	PAST EXPERIENCE	[7]	54
	EXPLANATION BY CLIENT	[8]	55

6. COUNSELLING:

(Client, Family Group or Community)

NUMBER & ORIGIN:	ME	[ ][ ]	56, 57
	SUPERVISOR	[ ][ ]	58, 59
	CLIENT	[ ][ ]	60, 61
	OTHER	[ ][ ]	62, 63
DEGREE OR PREPARATION:	NO EXPERTISE	[1]	64
	ALMOST NO EXPERTISE	[2]	
	MANY PROBLEMS	[3]	
	ONE OR A FEW PROBLEMS	[4]	
	NO PROBLEM AT ALL	[5]	
SOURCE OF PREPARATION: (tick as many as apply)	BASIC NURSING TRAINING	[1]	65
	POST DIPLOMA COURSE	[2]	66
	IN-SERVICE	[3]	67
	SUPERVISOR	[4]	68
	CO-WORKERS	[5]	69
	BOOKS, ARTICLES	[6]	70
	PAST EXPERIENCE	[7]	71
	EXPLANATION BY CLIENT	[8]	72

7. COORDINATION & LIAISON:

Negotiate for resources, arrange referrals, communicate, delegate tasks.

Start new Card
Duplicate
Cols. 1-4

NUMBER & ORIGIN:	ME	[ ][ ]	5, 6
	SUPERVISOR	[ ][ ]	7, 8
	CLIENT	[ ][ ]	9, 10
	OTHER	[ ][ ]	11, 12
DEGREE OR PREPARATION:	NO EXPERTISE	[1]	13 .
	ALMOST NO EXPERTISE	[2]	
	MANY PROBLEMS	[3]	
	ONE OR A FEW PROBLEMS	[4]	
	NO PROBLEM AT ALL	[5]	
SOURCE OF PREPARATION: (tick as many as apply)	BASIC NURSING TRAINING	[1]	14
	POST DIPLOMA COURSE	[2]	15
	IN-SERVICE	[3]	16
	SUPERVISOR	[4]	17
	CO-WORKERS	[5]	18
	BOOKS, ARTICLES	[6]	19
	PAST EXPERIENCE	[7]	20
	EXPLANATION BY CLIENT	[8]	21

8. FOLLOW-UP & REVIEW ACTIVITIES:

Observation, judgement, discussion, further tests, actions.

NUMBER & ORIGIN:	ME	[ ][ ]	22, 23
	SUPERVISOR	[ ][ ]	24, 25
	CLIENT	[ ][ ]	26, 27
	OTHER	[ ][ ]	28, 29

8. FOLLOW-UP & REVIEW ACTIVITIES (cont'd)

DEGREE OR PREPARATION:	NO EXPERTISE	[1]	30
	ALMOST NO EXPERTISE	[2]	
	MANY PROBLEMS	[3]	
	ONE OR A FEW PROBLEMS	[4]	
	NO PROBLEM AT ALL	[5]	
SOURCE OF PREPARATION: (tick as many as apply)	BASIC NURSING TRAINING	[1]	31
	POST DIPLOMA COURSE	[2]	32
	IN-SERVICE	[3]	33
	SUPERVISOR	[4]	34
	CO-WORKERS	[5]	35
	BOOKS, ARTICLES	[6]	36
	PAST EXPERIENCE	[7]	37
	EXPLANATION BY CLIENT	[8]	38

EVALUATION

9. DOCUMENTATION:

Fact finding, filling out forms, writing reports, revising case histories.

NUMBER & ORIGIN:	ME	[ ][ ]	39, 40
	SUPERVISOR	[ ][ ]	41, 42
	CLIENT	[ ][ ]	43, 44
	OTHER	[ ][ ]	45, 46
DEGREE OR PREPARATION:	NO EXPERTISE	[1]	47
	ALMOST NO EXPERTISE	[2]	
	MANY PROBLEMS	[3]	
	ONE OR A FEW PROBLEMS	[4]	
	NO PROBLEM AT ALL	[5]	
SOURCE OF PREPARATION: (tick as many as apply)	BASIC NURSING TRAINING	[1]	48
	POST DIPLOMA COURSE	[2]	49
	IN-SERVICE	[3]	50
	SUPERVISOR	[4]	51
	CO-WORKERS	[5]	52
	BOOKS, ARTICLES	[6]	53
	PAST EXPERIENCE	[7]	54
	EXPLANATION BY CLIENT	[8]	55

10. OUTCOME EVALUATION

NUMBER & ORIGIN:	ME	[ ][ ]	56, 57
	SUPERVISOR	[ ][ ]	58, 59
	CLIENT	[ ][ ]	60, 61
	OTHER	[ ][ ]	62, 63
DEGREE OR PREPARATION:	NO EXPERTISE	[1]	64
	ALMOST NO EXPERTISE	[2]	
	MANY PROBLEMS	[3]	
	ONE OR A FEW PROBLEMS	[4]	
	NO PROBLEM AT ALL	[5]	
SOURCE OF PREPARATION: (tick as many as apply)	BASIC NURSING TRAINING	[1]	65
	POST DIPLOMA COURSE	[2]	66
	IN-SERVICE	[3]	67
	SUPERVISOR	[4]	68
	CO-WORKERS	[5]	69
	BOOKS, ARTICLES	[6]	70
	PAST EXPERIENCE	[7]	71
	EXPLANATION BY CLIENT	[8]	72

Office use o

DESCRIPTION OF YOUR TYPICAL DAY

NUMBER ____

WHAT TYPE OF THING DO YOU OFTEN DO THAT YOU DIDN'T DO ON THIS DAY?

NAME _____

PLEASE TICK THE NUMBER CORRESPONDING TO THE RESPONSE DESIRED ✓

				1	2	-
1.	FIRST BASIC REGISTRATION	RN	1		4	
		RPN	2			5
		BN	3			
		OTHER	4			
		YEAR (last 2 digits)		___	___	6,
2.	CERTIFICATE(S)	COMMUNITY HEALTH	1	___		8
		PUBLIC HEALTH	2			9
		YEAR		___	___	10,1
		MIDWIFERY		___		12
		YEAR		___	___	13,1
		CHILD HEALTH		___		15
		YEAR		___	___	16,1
		OTHER (please state)		___		18
		YEAR		___	___	19,2
3.	DEGREE	NURSING		___		21
		NON-NURSING		___		22
		YEAR		___	___	23,2
4.	ADDITIONAL EDUCATIONAL PROGRAMS (as below)					
	.....					25,2
	.....					
	.....					
5.	FUNCTIONAL CATEGORY	COMMUNITY FIELD NURSE - METRO	1			27
		RURAL	2			
		OUTPOST NURSE				28
		CHILD HEALTH NURSE - METRO	1			29
		RURAL	2			
		HIGH SCHOOL HEALTH NURSE - METRO	1			30
		RURAL	2			
		DISTRICT SCHOOL HEALTH NURSE - METRO	1			31
		RURAL	2			
		PRIORITIES SCHOOL HEALTH NURSE - METRO	1			32
		RURAL	2			
6.	TOTAL YEARS OF EXPERIENCE IN COMMUNITY (NON-HOSPITAL) NURSING			___	___	33,3

(please turn over)

BEST COPY AVAILABLE

Office use on

YOUR RECOMMENDATIONS

REFLECTING ON YOUR WORK, WHAT WOULD YOU RECOMMEND FOR:

(a) CONTINUING EDUCATION OR INSERVICE THAT WOULD BE MOST USEFUL TO YOU IN FUTURE.

73-80

Start New Car
Dupl.Cols. 1-

(b) IMPROVEMENTS IN ALL PREVIOUS TRAINING THAT WOULD HAVE BEEN MOST USEFUL TO YOU.

73-80

(c) OTHER COMMENTS.

PLEASE MAIL THE FORMS TO ME AS SOON AS POSSIBLE. THANK YOU.

Appendix G: Reminder Notice

GRAPEVINE

AUGUST, 1984

HEALTH DEPARTMENT OF WESTERN AUSTRALIA

A NOTE FROM ANNE McMURRAY

Many thanks to all research study participants who have supplied a wealth of information about the role of the community based nurse. Several nurses returned their survey forms with the cover sheet missing, and this portion is necessary for coding the questionnaires. Therefore, if you still have yours, (it is page number 3), please drop it in the mail to me, or if it is more convenient, ring me and I'll take your information over the phone. I hope to have the survey results for you by September 1st.
If you have not returned your survey - please do so promptly.
Once again, a warm thank you.

NOW AVAILABLE

NEW SETTLERS GUIDE - The Department of Immigration and Ethnic Affairs has recently published a compact but very informative booklet for migrants and refugees. It is called LIVING IN AUSTRALIA, and contains advice on emergencies, accommodation, learning English, employment, education, health, car ownership, neighbours, migrant rights, the police, the law, and recreation. Now available in English, it will soon also be printed in ARABIC, CHINESE , FRENCH, GERMAN, GREEK, ITALIAN, KHMER, LAO, POLISH, PORTUGUESE, SPANISH, TURKISH, VIETNAMESE.

MEDICARE - enrolment form information is now available in ARABIC, CHINESE, CROATIAN, GREEK, INDONESIAN, ITALIAN, KHMER, LAO, MACEDONIAN, MALTESE, POLISH, PORTUGUESE, SERBIAN, SPANISH, TURKISH AND VIETNAMESE.

EAT YOUR WAY TO GOOD HEALTH - a straightforward summary of the latest nutritional advice - is now available in eleven languages. These are ENGLISH, ITALIAN, PORTUGUESE, SPANISH, GREEK ARABIC, CHINESE, VIETNAMESE, CAMBODIAN, GERMAN, SERBIAN, CROATION, and TURKISH. (RUSSIAN, MALTESE, POLISH, LAO can also be ordered if you need them).

HEALTHY TEETH AND GUMS - is also available in several ethnic community languages. It covers the reasons for dental health, causes of caries and gum disease, prevention and dental services in Australia.

FIRST FOODS FOR BABY - (CAMBODIAN) is an attractively illustrated sheet specially produced by Ethnic Liaison at the request of Child Health nurses.

Current listing of HEALTH-RELATED WRITTEN MATERIALS IN ETHNIC LANGUAGES - now available. (A copy will be included in the folder handed to participants at the COMMUNITY NURSES' INSERVICE EDUCATION WEEK).

ENQUIRIES: - SANDY HOPKINS (Ethnic Liaison 322 3211.

HEALTH CARE CARDS - An excellent poster showing actual examples of the seven different kinds of SOCIAL SECURITY CARDS with details of eligibility is now available from SOCIAL SECURITY on 320 3294.

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Appendix H. Additional Educational Programmes Attended by Nurses

Clinical Courses

1. Drug Dependence
2. Bachelor of Health Sciences (Nursing) Courses
3. Spinal Injuries
4. Opthalmology
5. Theatre - Plastic Surgery
6. The Premature Infant
7. Neonatal Care
8. Paediatrics
9. Neonatal Intensive Care
10. Thoracic Nursing
11. Adult Intensive Care
12. T.B. & Chest Conditions
13. Nurse Practitioner Training
14. Kinesthetics
15. Nutrition
16. Fitness
17. Massage
18. Arthritis
19. Immunisation
20. Human Biology
21. Sports Training
22. Accident & Emergency Nursing
23. First Aid Instruction
24. Alcoholism
25. Vision Disabilities
26. General Nursing Refresher Course
27. Midwifery Refresher Course
28. Yearly Conference (Public Health)
29. Orientation (Public Health)
30. Yearly Inservices (Public Health)

Education Courses

31. Health Education
32. Teaching/Learning Process
33. Computer Appreciation
34. Instructional Techniques
35. Dyslexia

Self Development Courses

36. Stress Management
37. Business Administration
38. Administration
39. English

Social & Human Relations Courses

40. Theology
41. Thai Language & Customs
42. Counselling
43. Parent Effectiveness Training
44. Psychology
45. Bachelor of Arts (Social Sciences) Courses
46. Family Planning
47. Welfare Psychology
48. Sexual Abuse
49. Croation Language
50. Culture & Mental Health

APPENDIX I

FREQUENCY OF OCCURRENCE OF INDIVIDUAL TASKS ACCORDING TO FUNCTIONAL CATEGORIES (N=96)

TASKS PERFORMED	FUNCTIONAL CATEGORIES													
	FIELD		OUTPOST		CHILD		SCHOOL		ALL URBAN		ALL RURAL		ALL NURSES	
	Ave.*	%	Ave.*	%	Ave.*	%	Ave.*	%	Ave.*	%	Ave.*	%	Ave.*	%
History Taking	28.78	12.25	29.50	9.46	37.19	14.49	62.67	28.86	43.41	17.87	45.64	18.19	44.20	17.99
Resources Identification	20.44	8.70	31.00	9.94	20.42	7.96	9.94	4.26	15.29	6.30	20.23	8.06	17.14	6.94
Deciding Priorities	22.83	9.72	10.50	3.37	20.40	7.95	16.30	6.99	17.00	7.00	21.32	9.30	19.23	7.83
Direct Care Giving	20.11	8.56	22.00	7.05	19.35	7.54	25.61	10.93	20.77	8.55	23.39	9.32	21.69	9.11
Teaching	26.06	11.09	68.00	21.79	31.05	12.10	23.67	10.15	26.71	11.00	31.32	12.49	28.34	11.54
Counselling	18.50	7.87	9.50	3.04	23.77	9.26	9.09	3.90	16.55	6.81	19.06	7.60	17.43	7.10
Coordination & Liaison	17.72	7.54	10.50	3.37	10.12	3.94	7.55	3.24	8.87	3.65	13.94	5.56	10.66	4.34
Follow-up & Review	17.44	7.42	24.00	7.69	20.35	7.93	8.48	3.63	15.19	6.25	16.91	6.74	15.80	6.43
Documentation	44.67	19.01	97.50	31.25	56.37	21.96	59.03	25.30	65.68	27.04	38.21	15.23	55.94	22.77
Outcome Evaluation	18.39	7.83	9.50	3.04	17.67	6.88	10.97	4.70	13.40	5.52	18.85	7.51	15.33	6.24
ALL TASKS	234.94	100	312.00	100	256.69	100	233.31	100	242.87	100	250.86	100	245.66	100

* Figures represent the average of responses on three survey days.

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APPENDIX J

FREQUENCY OF OCCURRENCE OF INDIVIDUAL TASKS ACCORDING TO EDUCATIONAL CATEGORIES (N=96)

TASKS PERFORMED	EDUCATION CATEGORIES											
	R.N. Only (1)		R.N. + 1-9 Other (2)		R.N. + 1 cert. + 1-9 Other (3)		R.N. + 2 cert. + 1-9 Other (4)		R.N. + 2 cert. + deg. + 1-9 Other (5)		All Levels	
	Ave.*	%	Ave.*	%	Ave.*	%	Ave.*	%	Ave.*	%	Ave.*	%
History Taking	41.08	18.92	66.75	22.01	26.50	10.73	46.50	16.22	25.33	7.65	44.26	17.99
Resources Identification	16.44	7.57	20.25	6.68	6.50	2.63	16.72	5.83	32.00	9.67	17.04	6.94
Deciding Priorities	16.89	7.78	24.00	7.91	6.75	2.73	26.22	9.15	21.00	6.34	19.72	7.93
Direct Care Giving	19.78	9.11	32.75	10.80	31.00	12.55	19.28	6.73	17.33	5.24	21.63	8.73
Teaching	25.12	11.57	25.33	8.35	36.50	14.78	35.67	12.45	49.00	14.80	28.34	11.54
Counselling	15.93	7.34	23.50	7.75	27.50	11.13	17.44	6.09	9.33	2.82	17.43	7.10
Coordination & Liaison	8.78	4.04	21.25	7.01	8.75	3.54	10.72	3.74	7.67	2.32	10.66	4.34
Follow-Up & Review	12.78	5.89	21.50	7.09	26.50	10.73	18.11	6.32	24.33	7.35	15.91	6.63
Documentation	48.10	22.16	53.25	17.56	70.50	28.54	66.78	24.00	124.67	37.67	55.94	22.77
Outcome Evaluation	12.20	5.62	14.67	4.84	6.50	2.63	27.17	9.48	20.33	6.14	15.33	6.24
ALL TASKS	217.1	100	303.25	100	247.00	100	286.61	100	330.99	100	245.66	100

* Figures represent the average of responses on three survey days.

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APPENDIX K

FREQUENCY OF OCCURRENCE OF INDIVIDUAL TASKS ACCORDING TO YEARS OF COMMUNITY-BASED NURSING (N=96)

TASKS PERFORMED	EXPERIENCE CATEGORIES											
	Less than 2 Years (1)		2 - 5 Years (2)		6 - 10 Years (3)		11 - 20 Years (4)		21 and Above (5)		All Levels	
	Ave.*	%	Ave.*	%	Ave.*	%	Ave.*	%	Ave.*	%	Ave.*	%
History Taking	35.60	15.40	38.50	15.23	54.89	22.53	39.95	14.85	27.25	20.84	44.20	17.99
Resources Identification	13.90	6.01	20.83	8.24	14.00	5.75	20.68	7.69	9.50	7.27	17.04	6.94
Deciding Priorities	12.10	5.23	21.88	8.65	20.42	8.38	19.55	7.27	9.00	6.88	19.23	7.83
Direct Care Giving	30.10	13.02	22.42	8.87	23.00	9.44	16.37	6.09	14.00	10.71	21.69	8.83
Teaching	28.90	12.50	29.63	11.72	23.75	9.75	36.32	13.50	16.75	12.81	28.34	11.54
Counselling	12.70	5.49	19.17	7.58	12.61	5.18	26.82	9.97	10.75	8.22	17.43	7.10
Coordination & Liaison	10.20	4.41	13.29	5.26	9.72	3.99	10.09	3.75	7.75	5.93	10.66	4.34
Follow-Up & Review	13.10	5.67	18.63	7.37	14.31	5.87	17.91	6.66	7.50	5.74	15.80	6.43
Documentation	49.90	21.59	53.08	21.00	58.06	23.84	64.32	23.91	23.25	17.78	55.94	22.77
Outcome Evaluation	24.70	10.68	15.42	6.10	12.83	5.27	16.95	6.30	5.00	3.82	15.33	6.24
ALL TASKS	231.20	100	252.85	100	243.59	100	268.96	100	130.75	100	245.66	100

* Figures represent the average of responses on three survey days.

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APPENDIX L

FREQUENCY OF OCCURRENCE OF SELF, SUPERVISOR, CLIENT AND OTHER-INITIATED TASKS ACCORDING TO FUNCTIONAL CATEGORIES OF NURSES (N=96)

SOURCE OF INITIATION	FUNCTIONAL CATEGORIES													
	FIELD		OUTPOST		CHILD		SCHOOL		ALL URBAN		ALL RURAL		ALL NURSES	
	Ave.*	%	Ave.*	%	Ave.*	%	Ave.*	%	Ave.*	%	Ave.*	%	Ave.*	%
Self	192.61	81.98	257.50	82.53	230.53	89.93	171.61	73.64	208.89	85.99	194.97	77.71	203.93	83.00
Supervisor	3.72	1.58	25.00	8.01	.37	.14	9.37	3.40	1.17	.48	10.82	4.31	4.59	1.87
Client	20.22	8.61	25.00	8.01	21.09	8.22	38.3	16.47	25.00	10.29	31.02	12.36	27.13	11.04
Other	18.38	7.82	4.50	1.44	4.37	1.70	13.74	5.68	7.85	3.23	14.05	5.69	10.06	4.09
ALL SOURCES	234.94	100	312.00	100	256.67	100	233.30	100	242.89	100	250.89	100	245.71	100

* Figures represent the average of responses on three survey days.

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APPENDIX M

FREQUENCY OF OCCURRENCE OF SELF, SUPERVISOR, CLIENT AND OTHER-INITIATED TASKS ACCORDING TO LEVELS OF EDUCATIONAL PREPARATION (N=96)

SOURCE OF INITIATION	EDUCATION CATEGORIES											
	R.N. Only (1)		R.N. + 1-9 Other (2)		R.N. + 1 cert. + 1-9 Other (3)		R.N. + 2 cert. + 1-9 Other (4)		R.N. + 2 cert. + deg. + 1-9 Other (5)		All Levels	
	Ave.*	%	Ave.*	%	Ave.*	%	Ave.*	%	Ave.*	%	Ave.*	%
Self	185.49	85.43	251.00	82.77	202.75	82.09	218.05	76.08	295.33	89.22	203.93	82.00
Supervisor	1.62	.75	10.08	3.32	.50	.20	9.44	3.29	17.33	5.24	4.59	1.87
Client	19.74	9.09	36.08	11.90	30.00	12.15	47.33	16.51	11.66	3.52	27.13	11.04
Other	10.25	4.72	6.08	2.00	13.75	5.57	11.77	4.11	6.66	2.01	10.05	4.09
ALL SOURCES	212.12	100	303.25	100	247.00	100	286.61	100	331.00	100	245.71	100

* Figures represent the average of responses on three survey days.

APPENDIx N

FREQUENCY OF OCCURRENCE OF SELF, SUPERVISOR, CLIENT AND OTHER-INITIATED TASKS ACCORDING TO YEARS OF EXPERIENCE IN COMMUNITY-BASED NURSING (N=96)

SOURCE OF INITIATION	EXPERIENCE CATEGORIES											
	Less than 2 Years (1)		2 - 5 Years (2)		6 - 10 Years (3)		11 - 20 Years (4)		21 and Above (5)		All Levels	
	Ave.*	%	Ave.*	%	Ave.*	%	Ave.*	%	Ave.*	%	Ave.*	%
Self	191.50	82.83	213.54	84.46	193.69	79.52	235.09	87.41	98.25	75.14	203.93	83.00
Supervisor	16.30	7.05	5.29	2.09	2.66	1.09	2.27	.84	1.25	.96	4.59	1.87
Client	18.20	7.87	24.66	9.75	33.47	13.74	24.00	8.92	24.50	18.74	27.13	11.04
Other	5.20	2.25	9.33	3.69	13.75	5.64	7.59	2.82	6.75	5.16	10.05	4.09
ALL SOURCES	231.20	100	252.83	100	243.58	100	268.95	100	130.75	100	245.71	100

* Figures represent the average of responses on three survey days.

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APPENDIX O

FREQUENCY OF OCCURRENCE OF SOURCE OF PREPARATION ITEMS ACCORDING TO FUNCTIONAL CATEGORIES OF NURSES (N=96)

TASKS PERFORMED	FUNCTIONAL CATEGORIES													
	FIELD		OUTPOST		CHILD		SCHOOL		ALL URBAN		ALL RURAL		ALL NURSES	
	Ave.*	%	Ave.*	%	Ave.*	%	Ave.*	%	Ave.*	%	Ave.*	%	Ave.*	%
Basic Training	13.33	15.14	7.50	8.67	14.70	14.54	13.58	21.56	12.24	15.82	16.94	17.01	13.91	16.32
Post-Diploma Course	7.72	8.77	10.50	12.14	12.30	12.17	3.58	5.68	8.19	10.59	8.79	8.83	8.41	9.87
Inservice	13.61	15.46	13.00	15.03	18.12	17.92	11.85	18.82	14.44	18.67	16.06	16.13	15.01	17.61
Supervisor	4.33	4.92	1.00	1.16	3.65	3.61	1.79	2.84	2.92	3.78	3.38	3.39	3.08	3.61
Co-workers	8.50	9.66	10.50	12.14	7.84	7.75	4.76	7.56	6.19	8.00	8.35	8.39	6.96	8.17
Books, Articles	12.78	14.50	14.50	16.76	12.98	12.84	5.70	9.05	8.45	10.92	14.15	14.21	10.47	12.28
Experience	18.94	21.52	17.00	19.65	19.65	19.44	15.76	25.02	17.08	22.08	20.03	20.11	18.13	21.27
Client Explanation	8.83	10.03	12.50	14.45	11.91	11.788	6.03	9.57	7.90	10.21	11.91	11.96	9.32	10.91
ALL SOURCES	88.03	100	86.50	100	101.10	100	62.98	100	77.35	100	99.58	100	85.24	100

* Figures represent the average of responses on three survey days.

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APPENDIX P

FREQUENCY OF OCCURRENCE OF SOURCE OF PREPARATION ITEMS ACCORDING TO LEVELS OF EDUCATIONAL PREPARATION (N=96)

SOURCE OF PREPARATION	EDUCATION CATEGORIES											
	R.N. Only (1)		R.N. + 1-9 Other (2)		R.N. + 1 cert. + 1-9 Other (3)		R.N. + 2 cert. + 1-9 Other (4)		R.N. + 2 cert. + deg. + 1-9 Other (5)		All Levels	
	Ave.*	%	Ave.*	%	Ave.*	%	Ave.*	%	Ave.*	%	Ave.*	%
Basic Training	14.73	18.19	9.67	14.07	4.00	9.47	16.67	15.06	11.33	8.11	13.91	16.32
Post-Diploma Course	6.83	8.43	1.92	2.79	3.50	8.29	16.28	14.71	24.67	17.67	8.41	9.87
Inservice	14.58	18.00	14.25	20.74	7.00	16.57	17.72	16.01	21.00	15.04	15.01	17.61
Supervisor	3.10	3.83	2.42	3.52	2.25	5.33	3.33	3.01	5.00	3.58	3.06	3.61
Co-workers	6.19	7.64	7.33	10.67	4.75	11.24	8.89	8.03	12.00	8.59	6.96	8.17
Books, Articles	9.69	11.96	9.33	13.58	2.50	5.92	13.44	12.14	23.00	16.47	10.47	12.28
Experience	16.95	20.93	17.92	26.08	13.50	31.96	21.89	19.78	25.67	18.38	18.13	21.27
Client Explanation	8.97	11.08	5.92	8.62	4.75	11.24	12.50	11.29	17.00	12.17	9.32	10.93
ALL SOURCES	80.99	100	68.71	100	42.25	100	110.69	100	139.65	100	85.24	100

* Figures represent the average of responses on three survey days.

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APPENDIX O

FREQUENCY OF OCCURRENCE OF SOURCE OF PREPARATION ITEMS ACCORDING TO YEARS OF EXPERIENCE IN COMMUNITY-BASED NURSING (N=96)

SOURCE OF PREPARATION	EXPERIENCE CATEGORIES											
	Less than 2 Years (1)		2 - 5 Years (2)		6 - 10 Years (3)		11 - 20 Years (4)		21 and Above (5)		All Levels	
	Ave.*	%	Ave.*	%	Ave.*	%	Ave.*	%	Ave.*	%	Ave.*	%
Basic Training	15.40	21.09	15.17	16.58	12.53	17.25	13.36	13.46	18.00	20.06	13.91	16.32
Post-Diploma Course	8.20	11.23	8.00	8.74	6.31	8.69	17.95	13.05	5.25	5.85	8.41	9.87
Inservice	13.00	17.81	16.92	18.49	12.08	16.63	17.95	18.09	16.75	20.89	15.01	17.61
Supervisor	4.10	5.62	3.88	4.24	2.78	3.83	2.73	2.75	.50	.56	3.09	3.61
Co-workers	6.40	8.77	8.67	9.47	6.22	8.56	6.45	6.50	7.50	8.36	6.96	8.17
Books, Articles	10.50	14.39	11.38	12.44	7.64	10.52	13.18	13.28	15.50	17.27	10.47	12.28
Experience	15.70	21.51	17.75	19.40	17.39	23.94	20.77	20.93	18.50	20.61	18.13	21.27
Client Explanation	9.70	13.28	9.79	10.70	7.75	10.67	11.86	11.95	5.75	6.41	9.32	10.93
ALL SOURCES	73.00	100	91.51	100	72.65	100	99.24	100	89.75	100	85.24	100

* Figures represent the average of responses on three survey days.

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APPENDIX R

FREQUENCY OF OCCURRENCE OF DEGREE OF PREPARATION RATINGS ACCORDING TO FUNCTIONAL CATEGORIES (N=98)

DEGREE OF PREPAREDNESS	FUNCTIONAL CATEGORIES													
	FIELD		OUTPOST		CHILD		SCHOOL		ALL URBAN		ALL RURAL		ALL NURSES	
	Ave.*	%	Ave.*	%	Ave.*	%	Ave.*	%	Ave.*	%	Ave.*	%	Ave.*	%
No Expertise	0	0	0	0	2	.21	12	1.97	7	.57	7	.97	14	.72
Almost No Expertise	3	.81	0	0	3	.32	15	2.46	15	1.23	6	.83	21	1.08
Many Problems	18	4.84	0	0	73	7.83	15	2.46	72	5.89	34	4.71	106	5.46
One or a Few Problems	175	47.04	8	25.81	458	49.14	206	33.83	472	38.63	375	51.94	847	43.57
No Problem	176	47.31	23	74.19	396	42.49	361	59.28	656	53.68	300	41.55	956	49.19
ALL RATINGS	372	19.14	31	1.59	932	47.94	609	31.33	1222	62.86	722	37.14	1944	100

* Figures represent the average of responses on three survey days.

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APPENDIX S

FREQUENCY OF OCCURRENCE OF DEGREE OF PREPARATION RATINGS ACCORDING TO LEVELS OF EDUCATIONAL PREPARATION (N=96)

SOURCE OF PREPAREDNESS	EDUCATION CATEGORIES											
	R.N. Only (1)		R.N. + 1-9 Other (2)		R.N. + 1 cert. + 1-9 Other (3)		R.N. + 2 cert. + 1-9 Other (4)		R.N. + 2 cert. + deg. + 1-9 Other (5)		All Levels	
	Ave.*	%	Ave.*	%	Ave.*	%	Ave.*	%	Ave.*	%	Ave.*	%
No Expertise	5	.45	5	2.00	1	1.43	3	.70	0	0	14	.72
Almost No Expertise	10	.89	9	3.60	0	0	2	.47	0	0	21	1.08
Many Problems	71	6.32	10	4.00	12	17.14	13	3.05	0	0	106	5.45
One or a Few Problems	531	47.28	95	38.00	32	45.71	174	40.85	15	20.00	847	43.57
No Problem	506	45.06	131	52.40	25	35.71	234	54.93	60	80.00	956	49.18
ALL RATINGS	1123	57.77	250	12.86	70	3.6	426	21.91	75	3.86	1944	100

* Figures represent the average of responses on three survey days.

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APPENDIX I

FREQUENCY OF OCCURRENCE OF DEGREE OF PREPARATION RATINGS ACCORDING TO YEARS OF COMMUNITY-BASED EXPERIENCE (N=96)

DEGREE OF PREPAREDNESS	YEARS OF COMMUNITY-BASED EXPERIENCE											
	Less than 2 Years (1)		2 - 5 Years (2)		6 - 10 Years (3)		11 - 20 Years (4)		21 and Above (5)		All Levels	
	Ave.*	%	Ave.*	%	Ave.*	%	Ave.*	%	Ave.*	%	Ave.*	%
Expertise	5	2.45	0	0	6	.89	3	.6	0	0	14	.72
Almost No Expertise	4	1.96	7	1.46	8	1.18	0	0	2	2.3	21	1.08
Many Problems	7	3.43	40	8.33	13	1.92	43	8.67	3	3.45	106	5.45
One or a Few Problems	111	54.41	254	52.92	264	39.00	165	33.27	53	60.92	847	43.57
No Problem	77	37.75	179	37.29	386	57.01	285	57.46	29	33.33	956	49.18
ALL RATINGS	204	10.49	480	24.69	677	34.83	496	25.51	87	4.48	1944	100

* Figures represent the average of responses on three survey days.

APPENDIX U

FREQUENCY DISTRIBUTION FOR DEGREE OF PREPARATION RATINGS FOR INDIVIDUAL TASKS (N=96)

DEGREE OF PREPARATION	TASKS RATED																	
	History Taking		Resources Identification		Deciding Priorities		Direct Care Giving		Teaching		Counselling		Coordination Liaison		Follow-Up & Review		Documentation		Outcome Evaluation		All Tasks	
	Ave*	%	Ave*	%	Ave*	%	Ave*	%	Ave*	%	Ave*	%	Ave*	%	Ave*	%	Ave*	%	Ave*	%	Ave*	%
No Expertise	1	.41	0	0	0	0	0	0	1	.49	4	1.94	1	.54	3	1.59	1	.44	3	2.19	14	.72
Almost No Expertise	3	1.23	1	.56	1	.52	3	1.67	0	0	5	2.43	3	1.61	2	1.06	2	.88	1	.73	21	1.08
Many Problems	11	4.51	10	5.59	13	6.81	7	3.89	9	4.39	18	8.74	10	5.38	9	4.76	11	4.85	8	5.84	106	5.45
One or a Few Problems	109	44.67	81	45.25	89	46.60	85	47.22	89	43.41	98	47.57	62	33.33	85	44.97	83	36.56	66	48.18	847	43.5
No Problems	120	49.18	87	48.60	88	46.07	85	47.22	106	51.71	81	39.32	110	59.14	90	47.62	130	57.27	59	43.07	956	49.18
ALL RATINGS	244	12.55	179	9.21	191	9.83	180	9.26	205	10.55	206	10.6	186	9.57	189	9.72	227	11.68	137	7.05	1944	100

* Figures represented the average of responses on three survey days.

Appendix V.i.

Individual Tasks Performed by Education Levels of Field and Outpost Nurses (N = 20)

TASKS PERFORMED	EDUCATION CATEGORY		
	R.N.	R.N.+1 cert.	R.N.+2 cert.
	N = 14	N = 0	N = 6
	Aver. #	Aver. #	Aver. #
History Taking	9.57	0	9.00
Resources Identification	10.09	0	9.33
Deciding Priorities	10.85	0	6.50
Direct Care Giving	12.22	0	4.63
Teaching	13.07	0	15.25
Counselling	10.14	0	3.92
Coordination & Liaison	8.28	0	3.25
Follow-up & Review	8.04	0	6.67
Documentation	14.44	0	39.25
Outcome Evaluation	10.47	0	2.75
All Tasks	10.72	0	10.06

Appendix V.ii.

Individual Tasks Performed by Education Levels of Child Health Nurses (N = 43)

TASKS PERFORMED	EDUCATION CATEGORY		
	R.N.	R.N.+1 cert.	R.N.+2 cert.
	N = 29	N = 2	N = 12
	Aver. #	Aver. #	Aver. #
History Taking	12.79	8.00	9.23
Resources Identification	6.79	4.50	7.45
Deciding Priorities	6.48	4.50	7.95
Direct Care Giving	6.41	4.00	9.41
Teaching	10.59	8.00	10.59
Counselling	7.72	17.00	4.23
Coordination & Liaison	3.38	6.00	3.00
Follow-up & Review	6.83	12.50	6.91
Documentation	17.31	34.00	16.73
Outcome Evaluation	6.07	4.50	8.46
All Tasks	8.44	10.30	8.40

Individual Tasks Performed by Education Levels of School Health Nurses (N = 33)

TASKS PERFORMED	EDUCATION CATEGORY		
	R.N.	R.N.+1 cert.	R.N.+2 cert.
	N = 28	N = 2	N = 3
	Aver. #	Aver. #	Aver. #
History Taking	21.22	10.00	36.00
Resources Identification	3.75	0	4.00
Deciding Priorities	4.90	0	14.67
Direct Care Giving	8.13	16.50	9.00
Teaching	5.37	14.59	23.67
Counselling	3.64	1.50	3.33
Coordination & Liaison	2.40	0	7.33
Follow-up & Review	2.27	5.00	10.33
Documentation	16.27	13.00	55.33
Outcome Evaluation	1.13	0	29.33
All Tasks	6.91	6.06	19.30

Appendix W.i.

Individual Tasks Performed by Experience Levels of Field and Outpost Nurses (N = 20)

TASKS PERFORMED	EXPERIENCE CATEGORY		
	0-2 yrs.	2-10 yrs.	11 + yrs.
	N = 1	N = 11	N = 8
	Aver. #	Aver. #	Aver. #
History Taking	5.00	11.77	8.70
Resources Identification	0	13.36	8.57
Deciding Priorities	0	10.63	4.80
Direct Care Giving	15.00	9.97	2.75
Teaching	13.00	11.29	14.10
Counselling	0	10.15	3.67
Coordination & Liaison	3.00	9.36	2.73
Follow-up & Review	2.00	9.31	6.27
Documentation	8.00	17.68	24.77
Outcome Evaluation	0	9.27	3.70
All Tasks	4.60	11.28	8.01

Appendix W.ii.

Individual Tasks Performed by Experience Levels of Child Health Nurses (N = 43)

TASKS PERFORMED	EXPERIENCE CATEGORY		
	0-2 yrs.	2-10 yrs.	11 + yrs.
	N = 4	N = 24	N = 15
	Aver. #	Aver. #	Aver. #
History Taking	10.25	12.42	11.57
Resources Identification	9.50	5.48	7.97
Deciding Priorities	8.75	6.02	6.79
Direct Care Giving	10.25	5.60	7.54
Teaching	9.75	9.40	14.04
Counselling	7.75	5.37	10.15
Coordination & Liaison	4.75	2.83	3.93
Follow-up & Review	9.75	6.43	5.64
Documentation	13.25	21.11	11.07
Outcome Evaluation	10.25	4.86	4.75
All Tasks	9.43	7.95	8.35

Appendix W.iii.

Individual Tasks Performed by Experience Levels of School Health Nurses (N = 33)

TASKS PERFORMED	EXPERIENCE CATEGORY		
	0-2 yrs.	2-10 yrs.	11 + yrs.
	N = 5	N = 25	N = 3
	Aver. #	Aver. #	Aver. #
History Taking	14.20	19.65	23.50
Resources Identification	2.00	3.35	1.00
Deciding Priorities	.80	6.11	2.00
Direct Care Giving	8.60	8.78	4.50
Teaching	9.00	8.78	8.00
Counselling	2.40	2.79	1.25
Coordination & Liaison	2.20	5.51	2.00
Follow-up & Review	.60	3.21	1.75
Documentation	21.00	16.50	33.00
Outcome Evaluation	8.40	2.10	4.50
All Tasks	6.92	7.68	8.15